UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

The Impact of Army life on a Mother's Decision-Making When Her Child is Unwell During the Out-of-Hours Period

by

Elizabeth Bernthal

Thesis for the degree of Doctor of Philosophy

March 2011

UNIVERSITY OF SOUTHAMPTON

<u>ABSTRACT</u>

FACULTY OF HEALTH SCIENCES

<u>Doctor of Philosophy</u>

THE IMPACT OF ARMY LIFE ON A MOTHER'S DECISION-MAKING WHEN HER CHILD IS UNWELL DURING THE OUT-OF-HOURS PERIOD

By Elizabeth Bernthal

This thesis describes a three-stage project using a qualitative case study approach. It explores in what way the features of Army life affect the daily lives of Army parents, how aspects of Army life influence the decision-making of mothers, and what support Army mothers expect when their child is unwell after their primary health care centre has closed (called the out-of-hours period).

  The study was conducted within an Army garrison in England. It occurred during an intense period of overseas operational deployment that left mothers as temporary lone parents for many months. Out-of-hours service provision had changed from an Army clinic within walking distance to an NHS provider located over thirty miles away.

  Phase One, using focus groups with 24 parents, identified how Army life affected parents and what their expectations were for health care provision in the out-of-hours period. During Phase Two, seven of these parents were interviewed to explore the themes identified in the previous stage in greater depth. Phase Three involved interviews with a further seven mothers who had accessed the out-of-hours clinic when their child had been unwell, to investigate the decision-making process that led to a consultation with a health professional.

  This study provides a rich and detailed description of how disruption, mobility and enforced separation affect parents living with young children within a garrison in England and the coping strategies that mothers used. It is distinctive as it theorises that emotional vulnerability caused by anxiety and fear during military enforced separation challenges a mother's fundamental sense of belonging. An algorithm developed from the findings demonstrates that a partner's presence influences whether the mother calls health care services as a first or last resort. Thus, it makes an important contribution to the development of both civilian and military knowledge regarding a mother's decision-making behaviour and her expectations for care when her child is unwell, particularly when a lone parent.

List of Contents

List of Figures

List of Tables

Declaration of Authorship

I, Elizabeth Bernthal, declare that the thesis entitled

'The impact of Army life on a mother's decision-making when her child is unwell during the out-of-hours period'

and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;

- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;

- where I have consulted the published work of others, this is always clearly attributed;

- Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

- I have acknowledged all main sources of help;

- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

- None of this work has been published before submission.

Signed: …………………………………………….

Date: …………………………………………….

Acknowledgments

I dedicate this thesis to all Army parents – particularly those who have taken part in this study and those who have been bereaved or suffered serious injury during combat.

I am indebted to all my supervisors for their time, encouragement, inspiration, mentorship and belief in me. I thank Professor Val Lattimer and Dr Abigail Burgess who set me on this journey. I thank Professor Judith Lathlean, Dr Mary Gobbi and my military adviser Colonel Robin Simpson (Defence Professor of General Practitioners) for continuing the journey and for seeing it to completion and whose support, encouragement, knowledge, wisdom and enquiring minds have been invaluable.

My thanks go to the Army's Joint Medical Command Defence Postgraduate Medical Deanery and the Royal Centre for Defence Medicine for funding this study, particularly at a time of such financial restraint. I thank my Reporting Officers who have released me from my military duties to attend university and Sylvia Jankowska from the Royal Centre for Defence Medicine for her valuable proof reading. I am grateful to all those who have helped me on this voyage of discovery in so many ways.

My deepest love and gratitude go to my husband Paul and daughter Rodena who have lived, loved and supported me through this journey. Paul has kept the home fires burning and never stopped believing that I would succeed, while Rodena has learnt the importance of striving for a goal and the joy of achievement. I thank them with all my heart.

Army terminology and definitions

Army family (f- lower case) - 'family' in the traditional nuclear sense; in which one or both parents have one or more dependant children living with them at their permanent address but without the presence of extended family (such as mothers, sisters, uncles or grandparents).

Army Family (F – upper case) –The family of the Army such as a serving soldier's Corps or Regiment which has its own strong traditions and affiliations with which Army personnel develop very strong ties of loyalty. As with any 'family', it is important for everyone within the Corps or Regiment to support each other. This ethos is fundamental to the internal philosophy of the Army (Ministry of Defence 2008a).

Army mother/ parent - A mother/mother or father who is either serving with the British Army or is married to a serving soldier or officer and who has at least one dependant child.

Army Primary Health Care Service (APHCS) - The organisation within the Army Medical Services that is responsible for the safe and effective provision of primary health care for Army personnel and their families within the United Kingdom. Its role is to enhance and sustain the operational effectiveness of the Army and the professional training of the staff who work within it (Ministry of Defence 2004).

'**Army wife'** - A colloquial descriptor used commonly by serving and non-serving personnel to refer to wives of a serving soldier or officer, regardless of their serving status, irrespective of whether a parent or not.

Artillery - Soldiers trained to fight with large projectile weapon systems, a group of artillery soldiers is called a Battery (Ministry of Defence 2010b).

'Bluey' - A colloquial descriptor used to refer to a blue coloured aerogramme supplied free of charge to deployed personnel and their friends and family by the Ministry of Defence. This can be sent either by the postal system or sent electronically ('e-bluey') with photographs attached to enable friends and family to communicate with deployed personnel free of charge (Ministry of Defence 2009, 2010c).

Chain of Command - A structured hierarchical system within the Army in which all serving personnel know who their seniors, peers and subordinates are as well as where in the hierarchical structure they are positioned themselves (Ministry of Defence 2007).

'Civi(s)' or 'Civi. Street' - Short for 'civilians'. A colloquial descriptor used by military personnel and their families to refer to all individuals outside a military population.

'Commissioned' officer - 'Commissioned' refers to the terms under which an officer is recruited to the Armed Forces, the exact terms of which vary within each Service and specialisation of each Service. All officers hold the 'Queen's Commission' and are 'commissioned' by the Sovereign to serve in a command position, in contrast to 'enlisted' soldiers who are 'non-commissioned' (Defence Analytical Services Agency 2011a).

Corps - A body of soldiers and officers who share a specialist area of expertise and who provide a specific logistical function such as medical care (e.g. the Royal Army Medical Corps) or mechanical engineering (e.g. the Royal Mechanical and Electrical Engineers) to the Regiment in the garrison to which they are allocated (Defence Analytical Services Agency 2011a).

Defence Analytical Services and Advice (DASA) (formerly Defence Analytical Services Agency until 2009) - A statistical organisation within the Ministry of Defence. Its role is to compile staffing, financial and logistical statistics to provide professional analytical, economic and statistical services and advice to the Ministry of Defence, Parliament, Ministers, Senior MoD Officials and other Government Departments, mainly through its publication of Defence related national statistics (Defence Analytical Services Agency 2011a).

Garrison - An Army camp which has its own headquarters and more than one barracks. A "garrison town" is a common expression for any town that has an Army garrison within its community. There are six garrisons in England. The term 'garrison' refers to Army camps only. (The term 'Station' refers to the Royal Air Force and 'Her Majesty's Ship' to the Royal Navy even if on dry land) (Armed Forces 2011).

'Global War on Terrorism' - Military operations conducted against terrorist organisations, particularly militant Islamist groups such as al-Qaeda. The campaign is led by the United States and the United Kingdom and is supported by other countries. It was launched in 2001 by the invasion of Afghanistan, followed by the Iraq War in 2003. The term 'Global War on Terror' was first used by the former United States President George W. Bush to denote a global military, political, legal and ideological campaign in response to the attacks in New York on 11th September 2001. This term has not been used since the present President of the USA (Barack Obama) came to office in 2009 but is still used by the media (House of Commons Foreign Affairs Committee 2006).

Harmony Guidelines -   A set of guidelines that states that soldiers must have less than 415 days of military enforced separation within a period of 30 months to provide Army families some stability and protection from separation (Ministry of Defence 2009).

Improvised Explosive Device (IED) - A homemade bomb constructed and deployed in ways other than in conventional military weapons. It is designed to cause death or injury by using explosives alone or in combination with toxic chemicals, biological toxins, or radiological material. IEDs can be produced in varying sizes, functioning methods, containers, and delivery methods. They are unique in nature because the IED builder has had to improvise with the materials at hand. An IED is known also as a 'roadside bomb' or 'booby trap' (Wilson 2005).

Individual 'Augmentee' - A soldier or officer serving with a Corps who is attached to a deployed Unit as an individual, usually to provide logistical support such as engineering, or specialist telecommunications (Ministry of Defence 2010c).

Infantry - Soldiers trained to fight on foot to make contact with and destroy the enemy on the ground. A group of infantry soldiers is called a Battalion (Ministry of Defence 2010b).

Insurgent - A person who takes part in an uprising or rebellion against a constituted authority (for example, an authority recognised as such by the United Nations) (Ministry of Defence 2010a).

Logistical support - Equipment and services to facilitate soldiers to undertake their task e.g. vehicles to transport soldiers (Ministry of Defence 2010b).

Medical centres - Army medical centres are primary health care centres that are either 'Soldier medical centres' or 'Family medical centres'.
'<u>Soldier medical centres'</u> treat serving Army personnel only. The family of the serving soldier or officer must register with a local NHS practice.
'<u>Family medical centres'</u> allow the nuclear family of the soldier or officer to register at the same primary health care centre as the serving member of their family.

Mess - The place and building in which serving personnel and their families socialise. Their entitlement to membership is dependent on their rank. Officers and their families are entitled to membership of the Officers' Mess. Non-Commissioned Senior Officers, of the rank of sergeant and above, and their families are entitled to be members of the Warrant Officers' and Sergeants' Mess. Single officers or Non-Commissioned Senior Officers live in their respective mess also. Soldiers of the rank of private and corporal are not entitled to be a mess member but are permitted to be a member of the Junior Ranks Club (Ministry of Defence 2010b).

'Military Covenant' - The mutual obligation between the Government, society and the Army to support Army personnel as compensation for the sacrifices which they are prepared to make by putting the Army before their own needs. The provision of subsidised Army accommodation as compensation for frequent mobility is an example (Ministry of Defence 2007).

Military ethos -. This is the high degree of commitment, self- sacrifice and mutual trust that the Army expects all serving personnel to demonstrate, which together are thought essential to ensure maintenance of morale. This is the '*spirit that inspires soldiers to fight'* (Ministry of Defence 2000, p 1).

Mission - The British Army exists to defend the nation and serve the United Kingdom's interests. Army personnel must carry out any task that the Army requires of them in order to complete the Government's objectives (Armed Forces 2011).

Non-Commissioned Officers (NCO) - Enlisted soldiers from the rank of Lance Corporal to Warrant Officer Class One (Defence Analytical Services Agency 2011a).

Oath of Allegiance - All officers and soldiers must take an Oath of Allegiance on joining the Army. Those who believe in God use the following words:

> *I swear by almighty God that I will be faithful and bear true allegiance to Her Majesty Queen Elizabeth II, her heirs and successors and that I will as in duty bound honestly and faithfully defend Her Majesty, her heirs and successors in person, crown and dignity against all enemies and will observe and obey all orders of Her Majesty, her heirs and successors and of the generals and officers set over me.*

Those from other religions replace the words *"swear by almighty God" with "solemnly, sincerely and truly declare and affirm".*(Ministry of Defence 2008b, p 9)

(Military) Operation(s) - military action (usually in a military campaign) using deployed forces (Armed Forces 2011).

Operational tempo - The intensity of military action and execution of military activity (Ministry of Defence 2007).

Operational unit - A cohesive group of soldiers who are able to deploy (Armed Forces 2011).

Regiment - A body of infantry or armoured soldiers who move together as one cohesive unit for the entirety of their Army career. It usually contains approximately 650 soldiers (including its officers) depending on its cap badge and role e.g. The Royal Welsh Regiment (Defence Analytical Services Agency 2011a).

Rest and recuperation (known as 'R and R') - The 14 days leave (including travelling time) that serving personnel are entitled to during a deployment of six months or over to allow them to visit their family at home (Ministry of Defence 2010c).

Serving - Members of the Armed Forces who hold a rank. For the purposes of this study, 'serving' relates to a mother or father who is serving with the Army irrespective of their rank while 'non- serving' relates to a mother who is part of an Army family but not serving herself.

Service (S - upper case) - From one or all of the three Armed Forces - The Royal Navy, the British Army, the Royal Air Force.

Short-toured - A colloquial descriptor when a posting or assignment is terminated earlier than the original end of tour date.

Soldier (S in upper case) - This denotes a generic term for an officer or soldier of either gender who is serving with the British Army regardless of rank.
(s in lower case) – 'soldier' denotes a Non-Commissioned Officer (NCO) of either gender.

'Storybook soldiers' – A story that service personnel can record for their children just prior to their deployment. This is so that their children can hear their voice and hear them tell them a story while they are deployed. Trained volunteer editors add music and sound effects to the story (e.g. Thomas the Tank Engine™). This scheme was developed in the garrison in which the study took place in 2007. It has been so successful that it is now available to all three Services (The Royal Navy, the British Army and the Royal Air Force) wherever they are serving (Defence News 2007, Eadie 2010).

'Time served' – Within an Army context, this refers to the length of time that a soldier or officer can serve with the Army. Soldiers (opposed to officers) have a career of 22 years while officers serving a Permanent Commission can serve until the age of 55 years old. Some soldiers are able to extend their service beyond the 22 year point (called a 'Long Engagement') if the needs of the Army dictate.

The 'wire' - A colloquial descriptor used commonly by serving and non-serving personnel (and by the participants in this study) to describe the secure military fence surrounding an Army camp. If accommodation or services (e.g. the garrison's medical centre) are 'behind the wire' they are inside the Army camp, so entitled personnel will have to pass a military security checkpoint to gain access.

'**Traditional values'** – An expectation by the Army that its personnel demonstrate self-discipline, selfless commitment, respect for others, courage, forbearance, integrity, loyalty, a high degree of personal and collective discipline and teamwork through challenging circumstances. Army personnel must be prepared to die to fulfil the Army's mission. These values are instilled in Army personnel during initial training. Officer Cadets have to demonstrate a high level of leadership and selfless commitment before they can 'pass out' as officers. A variety of leadership courses must be passed throughout all soldiers and officers' careers in order for them to be promoted to the next rank (Ministry of Defence 2008b).

Unit (U – upper case) - A cohesive group of serving personnel that have a function of either combat or combat support. Service personnel serving with a Unit are predominantly from one Service (e.g. Army) or a Branch of Service (e.g. logistics). It has an integrated administrative and command structure to ensure that it is self sufficient (Armed Forces 2011). An example is 22 Field Hospital.

Unit Welfare Officers (UWO) - The Senior Non-Commissioned Officer or junior officer who is the first point of contact for welfare assistance and advice for all soldiers and their families within a unit. The UWO advises the Commanding Officer of his Regiment or Corps of all welfare matters within his Unit (Ministry of Defence 2010c).

(Voluntarily) Unaccompanied - Some serving personnel elect to be 'Voluntarily Unaccompanied' in which the serving spouse's family chooses to remain in one location long term, normally in their own house, to allow stability for the family, such as continuity of schooling for their children. The serving spouse lives within his Army Unit during the working week, away from his established home, and returns home weekly or monthly depending on the distance of his post from his home.

List of Abbreviations

AMS	Army Medical Services
APHCS	The Army Primary Health Care Service
DASA	Defence Analytical Services and Advice
DH	Department of Health
ED	Emergency Department
GP	General Practitioner
MeSH	Medical Subject Headings
MoD	Ministry of Defence
MoD REC	Ministry of Defence Research Ethics Committee
MP	Member of Parliament
NATO	North Atlantic Treaty Organisation
NHS	National Health Service
PCT	Primary Care Trust
PHC	Primary Health Care
PIN	Personal Identification Number
R and R	Rest and Recuperation
SDSR	The Strategic Defence and Security Review
UK	United Kingdom
US	United States
USA	United States of America

Chapter 1 Introduction

1.1 Introduction

The Army in the 21st century is focused on defending the nation by supporting the Government's strategy to tackle the threat of terrorism to the United Kingdom (UK). As a result, Army life is characterized by exposure to danger for deployed personnel, and enforced separation and additional stress for their families. The element of danger is obvious, but the facts are stark. Historically, there is only one year (1968) since World War Two that British soldiers have not been killed in action (Wikipedia 2010). According to official statistics (Defence Analytical Services and Advice 2010), the number of soldiers killed in hostile action has doubled every year since 2005, while the number of soldiers seriously injured has increased seven fold between 2005 and 2009.

Support for the families of Army personnel is embedded within the culture of the Army. The Army as an organisation emphasizes its 'duty of care' and moral responsibility to support the soldier's family, as well as the soldier himself (Ministry of Defence 2008a, p 8). Its commanders recognise that Army wives, many of whom are mothers, make a considerable contribution to maintaining their serving husband's morale. Both politicians and the Army itself acknowledge that high morale is not only important for the psychological wellbeing of the soldier and his family, but also improves military effectiveness (House of Commons Defence Committee 2008; Strachan et al 2010).

The phenomenon of military enforced separation is not new. However, there is increased recognition of the impact that it can have on both serving personnel and those left at home. Thus, this aforementioned 'duty of care' is particularly important during times of separation when serving partners, usually husbands, are away on military duty and are difficult to contact. This characteristically leaves Army mothers at home to make decisions about the welfare of their children on their own.

Many Army mothers have children under five years old and frequently have to make decisions about their child when their child is unwell. Raphael et al (2010) conducted a study in a non-Army setting and recognised that mothers go through a complex decision-making process when their children are unwell, and that this is influenced by the mother's psychological state. Most mothers, irrespective of their circumstances, find that their child being unwell is a frightening experience, and even more so if it is in the middle of the night. Within an Army context, such

decisions may have to be made at a time of emotional vulnerability, when mothers may be fearful for the safety of their absent husbands.

Examining the decision-making process of Army mothers, and the factors that influence their decisions at a time when they may be at their most emotionally vulnerable, is a way to identify the type of support that Army mothers require during times of stress. However, this is an area where limited evidence exists, especially regarding the factors that impinge upon a mother's decision to access health services when her medical centre is closed. This time of day is referred to as the 'out-of-hours' period, when a patient's own primary health care centre is closed, such as during weekends, evenings and on Bank Holidays.

Taking these aspects into consideration, and influenced by my own desire as an Army midwife and Nursing Officer to help provide physical and emotional help to military families, this research study aimed to address the impact that Army life has on the decisions that mothers make when their child is unwell during the out-of-hours period. This study was undertaken during a particularly intense period of overseas operational military activity. However, it gives insight into the impact of Army life during any period of military enforced separation, regardless of the characteristics of the deployment. The insight that this thesis generates can be related to the help-seeking behaviour of any civilian mother undergoing enforced separation from her partner, or when making decisions about the care of a sick child on her own.

The thesis provides a rich and detailed description of what Army life is like for parents living with young children within a garrison in England. It explores how the features of Army life influence the decisions that mothers make and their expectations for support when their child is unwell during the out-of-hours period.

This introductory chapter gives an overview of the background to the study, introduces the research setting, design, aims and objectives, and culminates with an overview of the thesis.

1.2 The Army

To put the study in context, it is important to recognise that the Army has developed traditions and ways of living and working that are culturally different from the society it defends. The Ministry of Defence (2008b) highlighted that the Army expects its serving and non-serving personnel to demonstrate its "*traditional values*" of self-discipline, courage, forbearance, integrity, loyalty, a high degree of

personal and collective discipline and teamwork throughout potentially challenging circumstances. In practice, this means that Army families must comply with the need to relocate every two to three years as the serving member is assigned to a different post anywhere in the world. In addition to this, they must be prepared to live away from extended family and undergo frequent military enforced separation of up to nine months duration because of the serving member of the family undertaking deployment, training exercises or professional development training, during which his personal safety may be at risk.

A 'Military Covenant' was established in 2000 as a consequence of having to meet demands of Army life. This is defined as:

> *The mutual obligation between the Government, society and the Army to support Army personnel and their families as compensation for the sacrifices which they are prepared to make by putting the Army before their own needs.*
>
>   (Ministry of Defence 2007, p 1).

In 2008, politicians acknowledged that the intensity of fighting against insurgents in Afghanistan was increasing, and that Army families had *"exceptional demands placed upon them"* (Leader of the Opposition's Military Covenant Commission 2008, p 8). The implications of implementing the Military Covenant were being considered by the Government at the time that this research study was being planned, and again during the time of the fieldwork. This sharpened the need for evidence of the challenges that Army families faced. Government action taken towards the end of the study (in 2010) is discussed later in the thesis (see Chapter 6).

1.3 The provision of health care

As part of its role in fulfilling the Military Covenant, the Army Medical Services (AMS) have to ensure that primary health care health provision for Army personnel and their families is appropriate, accessible and of the same standard as the National Health Service (NHS) (Ministry of Defence 2008a, p 8). The Army Primary Health Care Service (APHCS) is an organisation within the AMS responsible for primary health care provision (Ministry of Defence 2004). In 2004, the document "*the National Quality Requirements in the Delivery of Out-of-Hours Services"* (Department of Health 2004a) set out standards that must be met for an out-of-hours service to be deemed safe and effective. APHCS was required to adhere to these standards just the same as any other out-of-hours provider in England, (Ministry of Defence 2004).

Since 2006, APHCS has contracted out provision of out-of-hours services to Primary Care Trusts (PCTs) in England In order to ensure a safe and effective service within its available budget. PCTs currently manage and provide NHS out-of-hours services. Since APHCS has commissioned PCTs to provide out-of-hours services for Army families, PCTs have consolidated their out-of-hours deputising services. This has meant that the nearest NHS out-of-hours clinic for Army families may now be located some distance from the garrison. For example, in this study, the nearest out-of-hours clinic was located over 30 miles (about a 40 minute car drive away) from the garrison, a significant change from the previous situation in which an out-of-hours clinic, provided by APHCS, was located within the garrison itself and within walking distance of where parents lived and worked. This has stimulated debate within APHCS, whether or not the increased distance to access medical services influences the decisions that Army parents make if their child is unwell in the middle of the night.

The transfer of out-of-hours health service provision to the NHS occurred at the same time as the Government's Foreign and Defence policy increased the commitment, length and frequency of unaccompanied deployments to Iraq and Afghanistan. 'Harmony Guidelines' sets a criteria that states that soldiers must have less than 415 days of military enforced separation within a period of 30 months to allow Army families some stability and protection from separation (Ministry of Defence 2009). This suggests an interval of two years between operational tours of six months' duration. Even though 'Harmony Guidelines' are 'guidelines' not policy, all Army Units are expected to abide by them (Ministry of Defence 2011a). However, in 2009, 46 per cent of Army troops were deploying more frequently than Harmony Guidelines recommended. This created up to 1500 lone parent families at one time in a garrison. Also, deployments of longer duration than six months were becoming more common (Ministry of Defence 2010a). This trend is expected to continue until 2015 at the earliest when the number of troops deployed to Afghanistan will be reduced (HM Government 2010a).

Readers who are unfamiliar with the Army context are referred to the Army terminology and definitions at the front of this thesis.

1.4 Development of the study

Prior to undertaking this study, and as part of my military role as a Nursing Officer within the garrison, I was aware that some Army parents were dissatisfied with their local NHS out-of-hours service provision when their children were unwell, particularly in terms of its accessibility. This anecdotal evidence indicated that

provision for out-of-hours care had become a very emotive issue for Army parents within the garrison, but I did not know why. In my role as a researcher, I attended a pre-organised routine weekly Regimental coffee morning with eight Army mothers whose husbands were deployed. This enabled me to explore informally whether the anecdotal evidence that I had heard regarding the dissatisfaction among some Army parents with their local NHS out-of-hours service provision was a view shared by these Army mothers. Also, it enabled me to determine whether a study to investigate parental decision-making during the out-of-hours period was viable.

It became evident during the discussion that accessing out-of-hours services when their child was unwell was a key issue for these Army mothers. This was particularly apparent during the periods of military enforced separation that occurred due to deployment, training exercises or courses, when their husbands were unavailable to support them. They also talked of their husbands' concerns regarding access to health care for their children. They expressed their appreciation and relief that the AMS was interested in exploring matters that affected their children's health care, and that a serving health professional had approached them in their own military environment to discuss the issues, rather than waiting for them to attend an appointment at the medical centre.

In light of their comments in the discussion, as well as the evidence in the literature, it was decided that a study should be undertaken to explore the decision-making of Army mothers. This would serve also to establish what Army life was like for Army parents within this garrison. To achieve this, it was clear that this study needed to gain the views of Army parents in the environment in which they lived and socialised. Before the study commenced, it was not evident whether serving status had an impact on the decisions that parents made or, whether it was common for Army fathers to be the primary carers of their children. Also, it was not known how usual it was for serving mothers to undertake military duties away from home and so not be at home to look after their children. Hence, before the impact of Army life upon decision-making could be explored, it was essential to gain the perspective of both mothers and fathers, irrespective of their serving or non-serving status.

The Army acknowledged the importance of me undertaking this study, and that my professional, academic, Army background and role as a Nursing officer within Army primary health care gave me credibility to complete the research. Also, I was in a post that could be influential in making recommendations to health service providers, policy makers and practitioners.

1.5 Study setting

This study took place in an Army garrison in England, situated within a civilian rural community. In common with other British garrisons, the garrison has a large military rural training area attached to it where soldiers from many other garrisons come to undertake training exercises. It also has a selection of local civilian amenities such as a civilian medical and dental practice, some shops, leisure facilities and two primary schools. Similar to other Army garrisons, the nearest Emergency Department is situated in the closest district hospital in the local town a driving distance away.

The garrison has been selected for this study as it is typical of other Army garrisons in the UK in that most types of military Units are represented, such as infantry and artillery Regiments, combat support including engineers and logistical support such as transport and health care. It is of one of the largest garrisons in the British Army and has up to 15,000 Army personnel and their families living and working within it.

Regiments stay in one location permanently, and so many Regimental families based within the garrison had lived and worked there for many years. On the rare occasion a Regiment relocates, it moves *en masse* as one cohesive Unit, so all the families allocated to that Regiment move together. At the time of the study, several infantry and armoured Regiments had recently moved to the garrison from British Forces Germany where they had been stationed for a significant length of time, whilst some other Regiments had been located in the garrison for several years.

A Regiment is not self-sufficient and requires logistical support such as medical care, transport or administrative support to enable it to fulfil its role. This is provided by specialised Corps personnel who are attached to the Regiment for the duration of their posting. This results in Corps functioning very differently from Regiments, as, unlike Regiments, Corps do not have one permanent location (except for one headquarters in the UK which consists of a small number of key personnel). As in all Army garrisons, Corps personnel are assigned to a Regiment on a two to three year posting cycle. As a result, in the study population, many of the Regimental families have remained static while there is a constant flow of individual Corps personnel and their families moving in and out of the garrison. The resultant mix of established and new Army families in the garrison allowed the option to recruit parents who had experience of a wider range of health care provision when their children had been unwell.

An Army garrison has a different demographic age profile from a civilian community. Army personnel can only serve between the ages of 17 to 55 years[1]; the age demographics of an Army population consists of adults who are under the age of 55 years (at least one of which will be serving) and their dependant children. The Army has a far greater proportion of under 25 year olds than the civilian population (Galahad SMS Ltd 2007). Thirty five per cent of the Army population are under 25 years old; many Army mothers are under 25 years old also and have several children of pre-school age (Defence Analytical Services Agency 2008a).

Serving personnel must register with their garrison's medical centre. Comparing the age demographics of the Army families registered with the garrison's medical centre to the patients registered with the local civilian General Practitioner (GP) practice provides an insight into the differing age demographics between the Army and civilian population from the same geographical area (Figure 1.1). Comparing data from the garrison's medical centre with data from the local PCT is particularly useful in this garrison, as most non-serving members of Army families are able to register at the garrison's (family) medical centre. In most garrisons, such comparisons would not be possible, as non-serving members must register at their local NHS practice as the garrison's medical centre treats serving personnel only.

Figure 1.1 demonstrates that this garrison has a higher percentage of children under four years old than the local NHS practice and shows that this Army population is younger than the local civilian one. Sixty four per cent of military patients registered in the Army practice are aged between 17 and 34 years old, while in the nearby civilian practice only 18 per cent of civilians registered belong to this age group and 33 per cent of civilian patients are over 55 years old.

---

[1] Some doctors may extend their service beyond 55 years old if the needs of the Army dictate because of a shortage of Army doctors during the present conflict in Afghanistan.

Figure 1-1 Comparison of age between an Army and a NHS practice
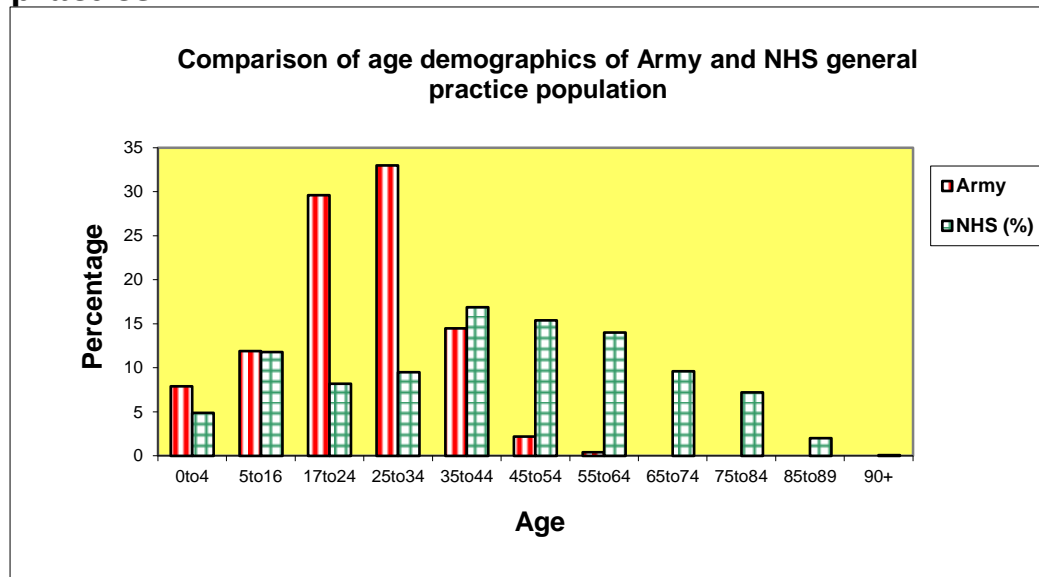
Statistics obtained by the garrison confirm that its Army population has nearly doubled since 2005, as many Regiments have relocated from British Forces Germany following the end of the Cold War. Despite the recent increase in size of the garrison, an audit of attendances by children from Army families at the NHS out-of-hours clinic has demonstrated that consultations have reduced since the service provision was commissioned to the NHS. Attendance rates altered from an average of 138 per month in 2005 when it was located within the garrison, to an average of 33 consultations in 2009 since it has been located over 30 miles drive away. Yet, children are known to attend out-of-hours clinics more than any other demographic group and 30 per cent of all attendances are children under two years old (Hendry et al 2005). An upsurge in the number of Army families within the garrison might have been expected to have led to an increase in attendance at the out-of-hours clinic by Army parents with their children. The fact that it did not suggests that there were factors that influenced parents not to attend. This raised the question as to why there was a decrease in attendance, which lent itself to a study to explore parental decision-making.

Army parents within the garrison have the same options for care when their child is unwell outside normal working hours as the civilians within the same community. In addition to accessing the out-of-hours clinic, parents have the choice to access the NHS emergency ambulance service (999) and NHS Direct. The nearest Emergency Department (ED) is located 18 miles away in the local district hospital, while the NHS Walk-in-Centre is 21 miles away from the garrison. The Minor-Injuries-Unit is the closest (12 miles away), but is a nurse-led Unit that is only

accessible between 08:30 to 21:30 hours. Therefore, the Emergency Department is the geographically closest medical facility to the garrison that provides 24-hour access to medical care.

1.5.1 The research questions and design

The informal discussion and the literature review identified that Army life had an influence on the decision-making of mothers when their children were unwell. However, it was not clear how, and in what ways, it influenced the decisions that Army mothers made. Studying the literature confirmed there was very little research that focused on the culture of the Army population, the impact of Army life on those within it, or the issues that influence the decision-making process of Army mothers when their children were unwell. The limited evidence strengthened my interest to explore these issues. The following research questions were developed as a result of these explorations:

1.   How (and in what way) do the features of Army life affect the daily lives of Army parents?

2.   How do aspects of Army life influence the decision-making of mothers when their child is unwell during the out-of-hours period?

3.   What support do Army mothers expect during the out-of-hours period when their child is unwell?

The research questions can best be addressed by a research design that values the perspective of the Army parents who actually undertake the decisions when their child is unwell. Therefore, a case study approach was used, and focus groups and in-depth interviews were undertaken with 31 serving and non-serving parents from within the garrison.

It is anticipated that the findings from this study will contribute to a greater understanding of the impact of Army life on the decision-making of Army mothers when their child is unwell during the out-of-hours period. Whilst located within one setting, the insight it provides can be theoretically generalised beyond this setting to similar contexts. For example, the findings should be transferable to all Service families and gives insight into the needs of Army families that can be used by health planners from all three Services (The Royal Navy, the Army and the Royal Air Force). It is transferrable also to other populations that undergo unaccompanied postings such as those from the United Nations and the Foreign and

Commonwealth Office or where enforced separation is a feature, such as the families of prisoners and other civilian parents making decisions on their own who find themselves in similar circumstances to the participants in this study.

1.6 Overview of the thesis

This chapter has introduced the study, explained the background and clarified the aim and the research questions for the study. Chapter 2 reviews the literature relating to the features of Army life, out-of-hours care and parental decision-making when a child is unwell. Chapter 3 discusses the study design, methods and process of analysis. Chapter 4 presents the findings regarding what Army life is like in addition to the findings regarding the decision-making of mothers and their expectations for support when a child is unwell. Chapter 5 discusses and reviews the findings of the study within the context of the literature. The final chapter, Chapter 6, reviews the research questions, summarises the key findings and discusses the strengths and limitations of the study. It offers recommendations for both the Army and NHS that are identified from this study and suggests priorities for future research.

Chapter 2 Literature review

2.1 Introduction

This chapter reviews the key literature related to the study. Section 2.2 explains the process that was used to identify and retrieve the literature. The literature is then reviewed in two sections - Section 2.3 explores the literature regarding Army life while Section 2.4 addresses the literature of help-seeking behaviour and the decision to consult. Theoretical concepts are incorporated within the review which explain why the features of Army life have such an impact on the decisions that Army mothers make when their child is unwell during the out-of-hours period.

The literature up to 2008 was reviewed in order to inform the research questions and design of the study. Subsequently, the literature was re-evaluated at later stages of the study as themes emerged from the data and new and important policy documents and papers were published and were incorporated into this final review.

2.2 The literature review process

The literature related to help-seeking behaviour and the decision to consult is located in medicine, nursing, sociology and psychology journals and texts. It was retrieved by electronically searching social science, and health related electronic databases as Hart (2004) recommends (see Appendix 1). Whilst military literature is found in these electronic sources also, most military literature is not electronically indexed on such databases and so individual journals had to be hand searched at the Defence Medical Services library.

Additional references were identified from key papers and reports, as well as from the Web of Science™ and Google Scholar™, which were used to confirm where papers had been cited. Pertinent government and Army reports and publications were retrieved from the relevant websites such as www.Armynet.mod.uk. Electronic library catalogues were searched for books and e-theses. Grey literature was searched for publications that had not been published, such as conference papers. Even though a rigorous process had been used, it was a challenge to ensure that all relevant military studies had been found because of the way that some studies were indexed. For example, Dandeker et al's (2006) study was identified by accessing the website for the North Atlantic Treaty Organisation (NATO) Research and Technology Organisation (www.rto.nato.int) and could not be retrieved through searching electronic literature databases such as Medline™.

Medical subject headings (MeSH) were used when searching the literature using Medline and Cumulative Index to Nursing and Allied Health Literature (CINAHL) (see Appendix 1.2). Combined database searches were undertaken when the key words, terms and subject headings were identical in the different databases being searched. A free-text strategy using key words was utilised in databases that did not have a well-constructed thesaurus, and were searched individually. Identifying references from previously retrieved papers and from those cited by the Web of Science™ proved to be the most successful method of retrieval.

Military literature was found using terms such as 'Army' and 'military personnel' which were combined with 'spouses', 'wives' and 'dependants'. However, few papers were identified despite using such a rigorous process of retrieval. Key search terms used can be seen in Appendix 1.3.

2.2.1 Selection criteria

Inclusion criteria were used to maximise retrieval of the relevant literature that focused on the issues related to Army life and the decision-making of mothers when their children were unwell during the out-of-hours period. The criteria for inclusion in the literature review were as follows:

- Health care literature was reviewed from 1984.
- Government policy documents were reviewed from 1997.
- Military literature was reviewed from 1975.
- Military policy documents relating to the out-of-hours service and health care provision for Army families were reviewed from 2000.

The specific dates quoted were chosen as the literature, policies and report documents generated after these dates were most likely to give the greatest insight into the impact of Army life and parental decision-making when a child is unwell during the out-of-hours period. Health literature was reviewed from 1984, as this was the beginning of the development of the present model of out-of-hours service provision. However, two earlier papers (Mechanic 1964 and Zola 1973) have been included also because of their particular relevance to this study. Government policy documents were reviewed from 1997, the year that the Labour Government came into power and the document *The New NHS Modern, Dependable* (Department of Health 1997) was published which had a major impact of health service provision within both the NHS and the AMS. There was a growth in military evidence assessing the impact of military enforced separation from 1975 onwards because of the increased occurrence of military conflicts during this period, such as the Vietnam War (1965-1975) involving troops from the United States of America (USA) and the Battle of the Falklands Islands involving troops from the UK in 1982. The

preliminary work to create APHCS began in 2000, therefore military policy documents and reports were reviewed from this date to enable the study to be placed into a military context.

Literature related to help-seeking behaviour and decision-making was included that originated from countries outside the UK in order to maximise insight. However, literature from overseas was only included if the out-of-hours health service provision of the country of origin of the research was similar to the UK. All types of published papers were included. A paucity of literature relating to the Army population in the UK highlighted the importance of including literature from all the British Armed Forces (i.e. the Royal Navy, the Army and the Royal Air Force) as well as literature from Armed Forces outside the UK. Military literature from other countries was included if, like the UK, the country of origin enlisted volunteers rather than used conscription, and had a similar command structure and ethos to the British Armed Forces.

The validity, methodological rigour and credibility of papers were assessed using the Critical Appraisal Skills Programme's (CASP) Critical Appraisal Toolkits (Public Health Resource Unit 2008; NHS evidence 2010). The appropriate tool for each paper was used (e.g. the qualitative assessment tool for a qualitative paper; review assessment tool for systematic reviews). The relevance of a paper's findings to my study was assessed also. Military literature exploring the impact of Army life originated from both the UK and the USA. Research investigating the decision to consult and help-seeking behaviour originated from many countries in addition to the UK, in particular Denmark, Sweden, the USA and to a lesser degree Australia and New Zealand.

2.3 Features of Army life

The aim of this section is to situate the study within the field of existing military literature regarding what Army life is like and how it impacts on Army families. Only one British research paper and six papers from the US could be retrieved which explored the features of Army life and their impact on the family that originated prior to this study commencing, confirming that this topic had received little attention before 2005. Only five more studies of relevance have been undertaken with sufficient methodological rigour since then, despite an increase in intensity of military action in both Iraq and Afghanistan since 2005, making a total of 12 papers to be reviewed.

Only four British sources undertaken with sufficient methodological rigour and relevance to warrant inclusion in this review have been identified. One paper is a literature review based on nine papers (Vincenti 1990), while another is a qualitative study which explored attitudes of a group of Army wives to childhood illness and their expectations of health provision (Giles 2005). Another study (Dandeker et al 2006) used a mixed methods approach to explore the deployment experiences of Army wives before, during and after deployment. Finally an unpublished doctoral thesis by Clifton (2007) is included, who completed an ethnographic study exploring Army children's' experience of education. Vincenti (1990) was the only British serving officer who had undertaken research, the other researchers (Giles, Clifton and Dandeker et al) were civilians who were commissioned by the British Army. These sources of military literature explore the impact of disruption and military enforced separation upon British Army families.

Owing to the paucity of British military literature, it has been necessary to review military literature from the USA. A total of eight papers were identified that met the inclusion criteria discussed in Section 2.2.1. Two of these papers are literature reviews, one of which consisted of fifteen papers (Blount et al 1992) and another listed twenty-six papers (Fitzsimons and Krause-Parello 2009). Three papers are quantitative studies (LaGrone 1978; Morrison 1981; Fernandez-Pol 1988, all of which investigated '*Military Family Syndrome*'. Another of the studies reviewed is a mixed method study by Ryan-Wenger (2002), who investigated the impact of the threat of war on children in military families. The remaining two studies reviewed are qualitative studies (Huebner et al 2007, Davis et al, 2011). Huebner et al (2007) investigated how deployment caused a sense of uncertainty and ambiguous loss in adolescents whose fathers were deployed, while Davis et al (2011) explored the deployment experiences of military wives. Notwithstanding the relevance of these papers to the topic, any US military studies must be reviewed with some caution

before their findings are considered relevant to the British Army population. This is because there may be features within the US Armed Forces that are different to those within the British Army, such as the differing length and frequency of deployment.

In deciding upon the focus of this review, it is well recognised that frequent mobility and military enforced separation are key features and an intrinsic part of Army life (Blount et al 1992; Ryan-Wenger 2002; Huebner et al 2007). Therefore, the relatively few papers that give insight into the impact of Army life are presented in terms of two themes – disruption (see Section 2.3.1) and military enforced separation (see Section 2.3.2). Earlier studies which focused on a different military and geographical climate such as the Cold War (LaGrone 1978; Morrison 1981) the Gulf War (Vincenti 1990) or the Balkan Conflict (Blount et al 1992) are included as they are still relevant to the contemporary context of this study.

2.3.1 Disruption of Army life

It was necessary to ascertain where and when the feature of disruption became a focus within the military literature and how this term is interpreted so that its impact could be explored. The earliest military literature that could be retrieved which related to the disruption of Army life originated from the US (LaGrone 1978; Morrison 1981; Fernandez-Pol 1988) preceded the earliest British paper (Vincenti 1990) by more than a decade. Three of the studies assessed the incidence of psychological disorders in Army families to demonstrate the disruption of Army life on military families (LaGrone (1978), on the children of Army personnel (Fernandez-Pol 1988), and on Army wives (Vincenti 1990). Disruption is viewed in the military literature in a variety of ways in terms of the impact of mobility. Vincenti (1990, p 78) used the term *"turbulence"* to reflect the disruption that frequent mobility and deployment caused the Army family. LaGrone (1978), Morrison (1981) and Fernandez-Pol (1988) undertook their quantitative research in the context of the US military during the Cold War, but they give some insight into Army life in general that is applicable to British Army parents.

LaGrone (1978) reviewed the case records of US Army children and adolescents seen in a US military clinic over a two-year period. Seemingly, this was the first study to focus on the military family and its relationship with the military as an organisation. He identified that the transiency of military life had an impact on the mental health of the families of serving personnel, not just serving individuals. LaGrone (1978) recognised that non-serving Army wives and their children were bound up with, and not exempt from, the pressures to which their husbands or fathers were subject. This study seems to be the first acknowledgement that the culture of military life is

an important factor that should be taken into account when caring for non-serving Army wives and their children

The size (n=792) and representativeness of the sample in this study provides confidence in the validity of the results, especially regarding the incidence of behavioural disorders in children and adolescents within US military families. The process that LaGrone (1978) used to review the case notes to formulate his conclusions is unclear, as no statistical analysis was included in the paper. Therefore, it is difficult to determine the methodological rigour of the research. Despite this, the issues that are explored within his paper give an important insight into the features of US service life that are relevant to the British Army in 2011, such as the impact of the military as an organisation on parents living within a military environment. LaGrone (1978, p 1041) identified that military families could be seen to be suffering from a new phenomenon at the time that he termed as "*Military Family Syndrome*". This phenomenon is noteworthy, as it is cited by 37 subsequent papers identified from the ISI Web of Knowledge™ and 67 subsequent papers retrieved from Google Scholar™[1] . Therefore it is important to include LaGrone's (1978) work here in order to explore what he meant by this term.

LaGrone (1978) identified that a higher incidence of behavioural disorders occurred in children and adolescents within US military families, the majority of whom (94 per cent) were from soldiers' families (as opposed to officers' families). He discovered from reviewing the case notes, that this was the result of certain features of military life which seemed to have a detrimental effect on the individual's concerned. These features included disruption, transience, the father's absence due to military commitments and the father's likely authoritarian parenting. He acknowledged also, that the family's relationship with the military and the husband-wife relationship had a major psychological impact on them as a military couple.

LaGrone (1978) identified that members of military families were resistant to being referred to a psychiatrist for fear of confidentiality being broken, officers seemed particularly reluctant. LaGrone (1978) surmised that this might have accounted for the unexpectedly small incidence of attendance by officers' families at the clinics of the case notes that he reviewed. A fear of confidentially being broken was a common theme in other studies. For example, Giles (2005) identified that the mothers taking part in her study within the British Army as recently as 2005, feared

---

[1] Confirmed 11 Oct 11

consulting their GP in case a breach of confidentiality occurred and their husband's superiors would be informed.

LaGrone (1978, p 1041) construed that military families lived within *"the military's rigid, autocratic system"*. LaGrone (1978, p 1041) recognised that serving personnel had such a strong bond with the military that non-serving individuals from "*outside*" the military organisation (i.e. those non-serving) threatened this relationship, even if from the soldier's own nuclear family. As a result, LaGrone (1978 p 1041) viewed the US military as a bureaucracy that had an "*authoritarian hierarchy that binds its members tightly*". LaGrone (1978 p 1041) concluded that living within such an "*authoritarian*" environment led to disempowerment of the non-serving wife, which relegated her to the status of a child. This strengthened the father's relationship with the military as an organisation even further and also increased his wife's sense of isolation as the non-serving "*outsider*" (LaGrone 1978, p 1041). This strong bond between the serving member of the family and the Armed Forces, not only made the soldier's family who were not serving feel excluded, but the disempowerment it created classified them as "*dependent*" (LaGrone 1978 p 1041). The term "*dependent*" is still used within the British Army today as is evident in the title to Giles (2005) paper *"Army dependents: childhood illness and health provision"*. Significantly, LaGrone (1978, p 1041) referred to military spouses as "*wives*" rather than 'mothers' indicating that there was something noteworthy about being married to a husband in the Armed Forces.

LaGrone (1978 p 1041) labelled the non-serving members of the family as "*an extension of the father"*. This assumed that the majority of serving personnel were men and fathers, while the mothers and children were non-serving members and dependant on the serving member to provide for them. Being "*an extension of the father*" enabled the soldier's family to enjoy certain privileges, such as free or government subsidised health care, but only as long as the father, as the serving member, remained serving (LaGrone 1978 p 1041). However, in order to benefit from these privileges the family had to comply with the demands of the military. These included relocating when and where they were required to do so and as frequently as every two years. This is less frequently than every 15 to 19 months that Vincenti (1990) established for the British Army, and so highlighting the subtle differences between the US and British Forces.

LaGrone (1978, p 1042) talked of a "*gypsy phenomenon"* in which the local civilian community were suspicious of military families because of their transiency, increasing a sense of isolation further. LaGrone (1978, p 1041) deduced that

anyone who did not comply with the military's demands was singled out as "*a scapegoat*" and targeted as the cause of trouble. It is not surprising then, that LaGrone (1978, p 1041) construed that military families lived within *"the military's rigid, autocratic system"*.

The work of Morrison (1981) and Fernandez-Pol (1988) has given insight into the meaning of LaGrone's (1978, p 1041) term "*Military Family Syndrome*", and in doing so both researchers provided a valuable interpretation of how disruption affects Army families. Morrison (1981) examined and compared retrospective data from both civilian and US military records (n=374). He was not able to conclude whether US military wives were more prone to psychological disorders because of the impact of Army life than their civilian counterparts, as there was a remarkable similarity between the data from both the civilian and military groups.

Unfortunately, little acknowledgement was given to the fact that as medical records are secondary data, their accuracy is dependent upon those completing the medical records in the first place. Nonetheless, his results confirmed that the pressures caused by frequent mobility and intermittent separation appeared to increase the incidence of serving fathers suffering from alcoholism. This was significant as, contrary to Morrison's (1981) original belief, his results supported LaGrone's (1978) conclusions that military life had significant features that made it different to civilian life.

Fernandez-Pol (1988) undertook a large-scale quantitative study of US Army families (n=423), and in doing so took Morrison's (1981) work one stage further. This study surveyed US military wives using a previously validated questionnaire to measure psychological distress. Fernandez-Pol (1988) selected participants from a group of military wives accessing a health clinic for routine screening. Similar to LaGrone (1978), Fernandez-Pol (1988) concluded that soldiers' wives reported more psychophysiological symptoms of stress than officers' wives did. Fernandez-Pol (1988, p 419) hypothesized that this may have been due to under-reporting by officers' wives due to their fear of *"being an encumbrance"* to their serving husband, as Giles (2005) concluded many years later. Fernandez-Pol (1988, p 420) recognised an inverse relationship between rank and the symptoms of distress of the wife, the lower the rank of the serving family member, the less developed the military wife's *"coping mechanisms"* seemed to be.

Fernandez-Pol (1988, p 419) suggested that frequent relocation, transience and removal from extended family as well as living within a "*rigid social hierarchy*" all

contributed to the phenomenon of "*Military Family Syndrome*". This study provided further evidence that the disruption caused by frequent mobility had a major impact on the entire family and not just those serving. Fernandez-Pol (1988, p 419) used the term "*uprooting*" to reflect the disruption caused by leaving extended family and loosing friends when military families relocated.

"*Rigidity*" was a common theme in many of the reviewed papers, but was interpreted in different ways within the literature. Fernandez-Pol (1988, p 418) inferred this to be "*the sacrifices*" of Army families, not in relation to serving personnel risking death, but in terms of the social isolation that resulted from the "*exigencies*" of military life which "*uprooted*" them from their extended family. This idea of rigidity provides a link with the British studies such as Giles (2005), who having conducted two focus groups and nine interviews with British Army wives, saw "*rigidity*" as positive and portrayed it as the caring paternalism of the British Army.

Dandeker et al (2006) interviewed 50 British Army wives with their husbands at the beginning and end of a deployment to Iraq for six months. In addition to this, they surveyed the wives halfway through the deployment. Dandeker et al's (2006) findings gave further insight into the impact of the "*rigidity*" of the Army on Army wives and recognised the frustration, but ultimate acceptance of British Army wives that they were expected to adhere to Army rules and regulations. Many wives perceived that the Army judged them by their husband's rank rather than on their own merits. Dandeker et al (2006) found that Army wives had no influence over such events as relocation and house moving, and had to accept that their serving spouse might depart on training exercises and deployments at any time. Dandeker et al (2006, p 400) concluded that the features of '*rigidity*' and the unpredictability of Army life could be grouped together as the "*non-negotiable demands of the military*". While the inability to plan day-to-day events was noted by Dandeker et al (2006) and in the literature reviewed by Vincenti (1990), it was not mentioned in the other papers.

Vincenti's (1990, p 78) literature review identified a number of possible factors that contributed to the disruption of Army life which he termed as "*turbulence*" rather than disruption. The aim of his review was to inform civilian colleagues who were caring for British military families what Army life was like, and so to help them be in a better position to support British Army families. It was not possible to ascertain whether the interpretations of the findings of the reviewed papers were plausible, or how rigorously the studies were undertaken, as the literature review process undertaken was not discussed in detail. Furthermore, Vincenti's own clinical role as

an Army psychiatrist and experience of consultations with soldiers who were mentally ill may have influenced his interpretation of the literature, particularly as he seemed to assume that both turbulence and military enforced separation had a similar impact and made Army wives susceptible to psychological disorders. Nevertheless, this literature review is worthy of inclusion here as it was the only one that could be found that gave a clear indication of what the features of disruption or "*turbulence*" were, and what made British Army life distinctive.

Vincenti (1990, p 78), drawing on the work of Jolly (1987), identified that living with such *"turbulence"* of frequent mobility and disruption were major stressors for all Service families, irrespective of the Service that they belonged to (i.e. whether from the Royal Navy, the Army or the Royal Air Force). His review of the remainder of the papers led him to conclude that frequent mobility reduced the likelihood of Army families living close enough to extended family to receive emotional and social support from them. He deduced that frequent mobility limited the opportunities for non-serving spouses (normally wives) to gain permanent employment, as employers were reluctant to employ a nomadic workforce. Vincenti (1990, p 78) grouped the features of the "*turbulence"* of Army life as the "*peculiarities of Army life*", and concluded that Army families were a minority group because of the impact that frequent mobility placed upon them.

Although Giles (2005) and Dandeker et al (2006) did not use the term 'turbulence', both papers concluded that the constant cycle of postings caused Army wives to suffer from stress and eroded their ability to cope. Also, Giles (2005) noted that frequent mobility made it more difficult for Army wives to access local health services. Giles (2005) recognised that there is an expectation by the Army as an organisation, as well as by the Army wives themselves, that Army wives have a role to play in supporting their husbands as part of the Military Covenant. As a consequence of this, the wives participating in her study perceived that the Army pressurised them not to let their own anxiety affect their husband's morale. On the other hand, they expected the Army to play its part by providing appropriate health care support to their child when unwell. They believed this was part of the Army's duty under the Military Covenant, as compensation for the emotional pressure that the Army put them under on a daily basis. Giles (2005) gives the first insight into how the Army's expectations of the wives of its serving personnel may influence their decision-making when their children were unwell.

While Giles's (2005) identification of the vulnerability of Army mothers could have been attributed to sampling from a group of mothers who had had treatment for

depression, her findings are consistent with those of Dandeker et al's (2006) a year later. Giles (2005) established that mothers frequently accessed primary health care for reassurance when their children were unwell, particularly if they feared meningitis. Fear of missing a serious diagnosis such as meningitis is a common fear for mothers and is explored in more detail in Section 2.4.

While LaGrone (1978), Morrison (1981) and Fernandez-Pol (1988) reviewed the incidence of psychiatric disorders as a means to identify the impact of features of Army life amongst children from military families, only Giles (2005) acknowledged that sampling from a group of patients with psychiatric disorders could influence the results or findings. She acknowledged that the mothers' depression may have increased their levels of anxiety. This is supported by other studies as for example, the participants in Dandeker et al's (2006) study were not known to suffer from mental illness and were not reported to suffer from the high levels of anxiety that Giles (2005) conveyed.

Clifton (2007) undertook an ethnographic study for her doctorate in which she observed and interviewed four 13 year old children from British Army families, their parents and teachers over a year. Unlike the military literature already reviewed, this is the only British study to explore the impact of disruption from the perspective of the child. Clifton (2007) concluded that Army children found it difficult to develop meaningful relationships at school. This was because their civilian peers viewed them as transient and that they would be relocating soon. Also, the Army children that took part in Clifton's (2007) study protected themselves emotionally by keeping their distance from other children to avoid the distress of saying goodbye to newly formed friends.

Clifton (2007) observed that some children developed physical symptoms of ill health, such as vomiting. It was unclear from her findings whether these symptoms were due to illness, but Clifton (2007) concluded that they were exacerbated by the anxiety of relocating and their fear that their father would be killed. The children's symptoms described in Clifton's (2007) study could reasonably be expected to result in an Army mother seeking professional help for her child. The study underlines the importance of the health professional's awareness of the circumstances in which an illness arose. As was evident in LaGrone's (1978), Giles's (2005) and Dandeker et al's (2006) study, the parents in Clifton's (2007) study were concerned that any criticism of the British Army might result in some form of retribution from their husband's superiors.

Both Giles (2005) and Dandeker et al (2006) acknowledged that their participants cited feelings of isolation and loneliness as a common feature of Army life. However, neither of these papers gave any detail of what they meant by these terms or how the participants in their studies experienced or interpreted isolation and loneliness.

The findings from both Giles's (2005) and Dandeker et al's (2006) studies concluded that the provision of practical support and the social events organised by Unit Welfare Officers in the Regiments played a major role in reducing the isolation and loneliness felt by Army wives and increased their sense of belonging within the Regiment. Both studies acknowledged that there were some inconsistencies between the welfare provision for families from Corps attached to Regiments and those serving with a Regiment, and that this led to greater feelings of isolation and loneliness for those from Corps. It can be hypothesized that the wives from Corps have a lesser sense of belonging than those from Regiments as a result. The concept of 'belonging' appears to be a key one. Clearly, whether the husband is serving with a Corps or a Regiment might have an impact on support that Army wives receive.

2.3.2 Military enforced separation

Morrison (1981), Dandeker et al (2006), Fitzsimons and Krause-Parello (2009) and Davis et al (2011) considered separation in terms of the periodic military enforced separation that results from deployment rather than training exercises or courses, while Davis et al (2011) viewed it in terms of the instability and uncertainty that deployment created. Separation due to deployment warrants special consideration, as a number of papers such as Blount et al (1992), Ryan-Wenger (2002), Dandeker et al (2006), Huebner et al (2007) and Davis et al (2011) have suggested that deployment is an intrinsic and critical feature of military life. The impact of military enforced separation has been explored on the whole family (Blount et al 1992), the non- serving spouse (Dandeker et al 2006; Davis et al 2011), the child of a deployed parent (Ryan-Wenger 2002; Fitzsimons and Krause-Parello 2009) and the adolescent (Huebner et al 2007). No research could be found which focused on the impact of deployment from the viewpoint of the deployed serving parent.

The literature views deployment in terms of unpredictability of both the departure and return of the deployed spouse (e.g. Ryan-Wenger 2002; Dandeker et al 2006; Huebner et al 2007; Fitzsimons and Krause-Parello 2009) as well as the risk of redeploying again soon after an individual had returned (Fitzsimons and Krause-Parello 2009). In fact, as Huebner et al (2007) emphasized, the only certainty about deployment is its uncertainty from beginning to end. Dandeker et al (2006)

established deployment to be the greatest cause of work-life tension for serving personnel. Dandeker et al (2006) identified that Army wives' separation from their husbands during long periods of pre-deployment training and deployments was their greatest source of dissatisfaction with Army life.

Vincenti (1990) drew on Morrice et al's (1985, p 480) work to explore the concept of *"intermittent husband syndrome"*. This was a term coined by Morrice et al (1985) during his research on the impact of separation on the wives of Aberdeen oil field workers who were apart from their husbands. Reviewing Morrice et al's (1985) research is useful to ascertain the impact that work related separation has on other civilian groups in order to tease out whether its features are applicable to the Army parents within this study. Prior to Vincenti (1990) undertaking his review, Morrice et al (1985) had interviewed 17 oil field workers and 30 wives of oil field workers who worked off-shore. Morrice et al's (1985) findings concluded that while the wives of Aberdeen oil field workers did not have financial worries, they identified themselves as one-parent families. Participants spoke of their frustration at having to cope alone without support, and of the constant readjustment to routine that intermittent separation demanded. It is clear from Morrice et al's (1985) paper that the wives of Aberdeen oil field workers were at their most anxious just before the departure of their husbands and on their husbands' return, when they found it hard to re-adjust to their previous roles and relinquish the additional functions that they had undertaken during their husbands' absence. Vincenti (1990) deduced that the psychological distress experienced by the wives of Aberdeen oil field workers during times of separation could shed light on how separation due to deployment affected British Army wives. Although, he acknowledged that the additional anxiety and fear felt during deployment compounded the impact of separation for Army wives and distinguished it from separation experienced by civilian groups. The insight gained from reviewing Morrice et al's (1985) work endorses the notion that exploring the impact of separation upon civilian groups increases the understanding of the impact of enforced separation upon Army families.

Blount et al (1992) undertook a descriptive literature review of 15 papers. In addition to sharing Vincenti's (1990) aim to provide information for other health care providers, they wanted to educate military health care providers in the clinical signs of stress in US military families. Blount et al (1992) identified that children and their parents suffered from a myriad of different symptoms that often resulted from the stress of taking on new roles during a period of military enforced separation. They recognised that requests for GP attendance with apparently insignificant symptoms during and after deployment indicated a reduced tolerance

to minor illnesses because of the stress of deployment. Also, both parents and their children benefited from being able to talk through their anxieties with a health professional. This appears to be the first evidence to concede that reunion is a major period of readjustment. The stress of the readjustment period caused them to develop physical symptoms that were significant enough for them to consult their GP. Blount et al (1992) warned that the medical team should remain vigilant long after reunion had taken place and that different deployments raised different stresses that could be interpreted differently by different individuals. By drawing on the work of Griffiths et al (1987), Blount et al (1992) concluded that supporting the family was not only important for their wellbeing but also had a positive impact on operational capability. This review challenged the assumptions of LaGrone (1982), Morrison (1981) and Fernandez-Pol (1988) that the experience of deployment was the same regardless of the individual's demographics or their perception of it.

Giles (2005) explored the tensions created by the impact of deployment and separation in two focus groups and nine interviews. Giles (2005, p 217) coined the term the '*turbulence cycle'*, not to define the disruption of Army life, but the turbulent "*fluctuating*" emotions that accompanied the stages of the deployment cycle for Army wives. As in Fitzsimons and Krause-Parello's (2009) review, participants talked of the establishment of a new normality that followed the spouse's departure, as well as the accompanying distressing emotions that felt similar to a bereavement. Participants acknowledged that their emotional state and "*fluctuating*" emotions could reduce their resilience and ability to make objective decisions when their children were ill. However, what constituted "*fluctuating*" emotions was not clarified. Davis et al (2011, p 55) termed this the "*roller coaster of contradictory emotions*" that all of the wives in their study seemed to suffer from regardless of their demographics. As Blount et al (1992) concluded from his review of US military literature, Giles (2005) established also that her participants visited their GP for reassurance more frequently during times of military enforced separation than when their husband was at home. Also, like Morrice et al's (1985) work with the wives of Aberdeen oil field workers, she concluded that reunion created tension because the marital relationship had to be renegotiated. She identified that concerns of infidelity made reunion as stressful as departure, while reverting to previous roles as if nothing had changed during the deployment was very challenging for the whole family. Giles (2005) highlighted that Army wives were very emotionally vulnerable despite their wish to cope and be resilient. LaGrone (1978) identified from reviewing military literature from 1968, that a soldier's prolonged absence due to military duty triggered an emotional crisis for their wives and children which resulted in an emotional reaction similar to

bereavement. In fact, this was one of the key drivers that motivated LaGrone (1978) to undertake his research. Blount et al (1992), Giles (2005) and Davis et al (2011) recognised deployment as an emotional cycle for the wife left as the lone parent at home and that this cycle mirrored whatever stage of the deployment her husband was undergoing at the time.

Davis et al (2011) interviewed 11 Army wives to explore their experiences during a US deployment. Davis et al (2011) concluded that US Army wives went through a series of stages, from emotional disorganisation at the beginning of a deployment to stabilisation prior to unification, Tellingly, Blount et al (1992, p 78) referred to the deployment stage as "*survival*" reflecting the pressures on the wife left at home. Although Fitzsimons and Krause-Parello's (2009) table of the five stages of deployment reflects the greater length and reduced frequency of military enforced separations within the US Army, it gives a useful depiction of what these stages are and of the emotional impact on the parent left at home. This can be viewed in Table 2.1.

Table 2-1   Stages of deployment for US Army

Stages of deployment	Duration of stage	Potential emotional impact on parent left at home
Pre-deployment	Five weeks to more than a year	Stress of anticipation, fear of not coping
Deployment	Departure to first month away	Loss - similar to bereavement- anger, sad, abandoned and alone
Sustainment	Second month to month before returning	Establishment of new routines and establishment of support network - mixture of emotions
Re-deployment	The month before returning	Mixture of emotions- anticipation, excitement, anxiety
Post-deployment	Reunion to six months after return	Readjustment creates its own stresses once the euphoria of a safe return is over

(Informed by Fitzsimons and Krause-Parello (2009)

Giles (2005) proposed that deployment for the British Army is represented best as a cycle rather than as a linear process and acknowledged that each phase of deployment created its own emotional challenges for the wife left at home. This may be because in the UK, serving personnel may enter the pre-deployment phase before they have completed the post-deployment phase, even if this contravenes Harmony Guidelines. In fact this is how it is depicted in the guides that the Army gives to its families when a member of their family deploys - *Guide for Families of deployed Regular Army Personnel* and *Guide for the families of mobilised members of the Territorial Army and the Regular Reserve* (Ministry of Defence 2010c). A

cyclical representation of deployment has been adapted from Giles (2005) and Ministry of Defence (2009, 2010c) and is represented in Figure 2.1.

Figure 2-1 The deployment cycle
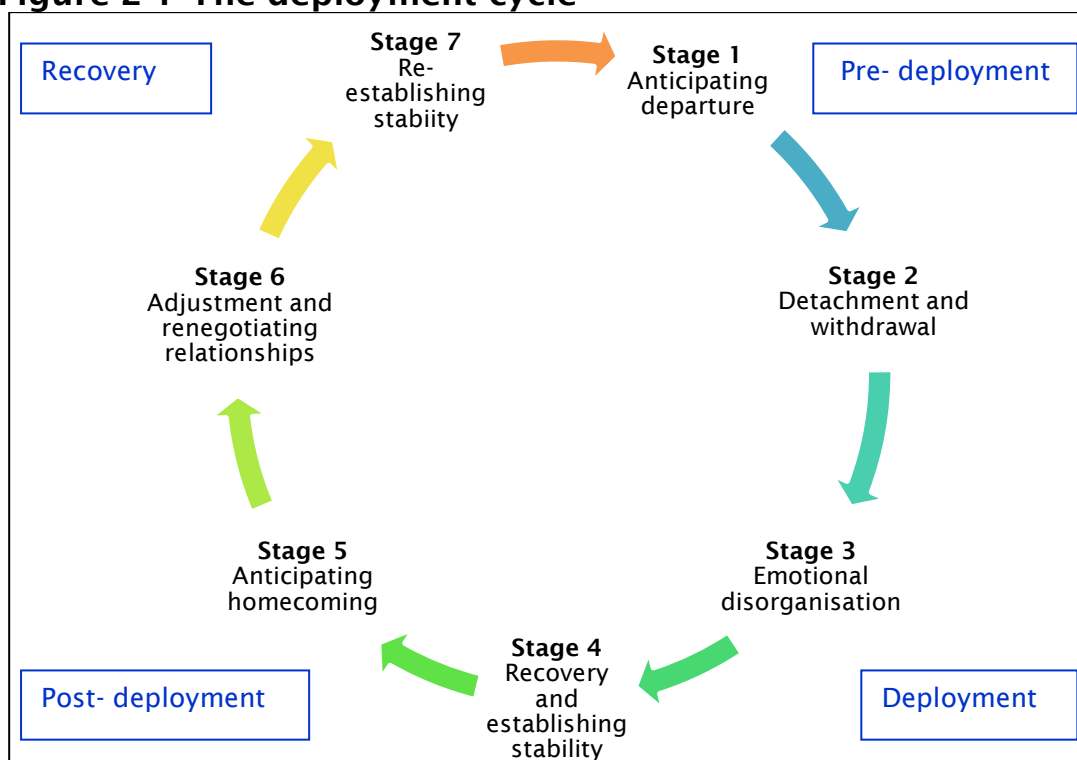
(Informed by Giles 2005 and Ministry of Defence 2009, 2010c)

Dandeker et al (2006) investigated whether Army wives sought different types of support depending on where in the deployment cycle they were. They demonstrated their understanding of its importance by incorporating three distinct phases of pre-deployment, during deployment and post-deployment into their study design. Dandeker et al (2006) and Fitzsimons and Krause-Parello (2009) highlighted that variations in the children's emotions and coping strategies were dependent on their age and whereabouts in the stage of the deployment cycle they were. Dandeker et al's (2006) survey confirmed that a father's absence led to a marked deterioration in his children's behaviour, a conclusion also reached by Blount et al (1992).

Knowledge of the context in which a study takes place is vital. It was clear from Dandeker et al (2006) that soldiers were more at risk of serious or fatal injury during some deployments than others, and that their location influenced the degree of difficulty with which they could communicate with their family at home. Dandeker et al (2006) recognised that anxiety levels of the wives, much to their surprise, decreased as the deployment progressed. Dandeker et al (2006) attributed this to his participant's perception of a reduction in the degree of danger

of that particular deployment in which less fatalities and serious injuries had occurred than had been expected. While LaGrone (1978) and Fernandez-Pol (1988) concluded that the anxiety demonstrated a lesser or greater degree of psychopathology, Dandeker et al (2006) deduced that anxiety was an appropriate and natural response, particularly as stress levels seemed to diminish as time passed.

A sense of loss caused by deployment was a recurrent theme in several of the studies from both the UK (such as Dandeker et al 2006) and the US (such as Huebner et al 2007; Fitzsimons and Krause-Parello 2009; Davis et al 2011). Dandeker et al (2006) and Davis et al (2011) viewed loss in terms of the additional emotional stress caused by the deployed parent missing special family occasions such as their child's birthday. The more events they missed, the more acute the deployed parent's absence was felt. Other studies such as Giles (2005), Huebner et al (2007), Fitzsimons and Krause-Parello (2009) and Davis et al (2011), saw loss in terms of the loss of the social interaction, quality family time and emotional support caused by the deployed person's absence. Davis et al (2011) established that the family at home used various strategies to cope with this, such as keeping busy and developing a social network, which were vital tools used to boost their resilience; while Dandeker et al (2006) identified that some Army wives utilised the period to learn new skills to make the time go more quickly. Giles's (2005) and Dandeker et al's (2006) studies conceded that wives faced additional demands and pressure at home because their husband was no longer able to share the running of the household or childcare responsibilities.

Huebner et al's (2007) findings from the focus groups that they undertook with adolescents whose fathers were deployed, illustrated that the father's absence created a sense of loss and altered adolescents' relationship with their mothers. The adolescents' change in role during the deployment was also found to cause deterioration of their mental health and reduce their ability to cope in stressful situations. The emotions expressed by these teenagers followed similar stages to the bereavement process seen in Fitzsimons and Krause-Parello's (2009) review. While Huebner et al (2007) debated whether or not the remaining parent could undertake additional tasks in the father's absence, the adolescents' feelings of loss meant that they felt unable to accept such substitution and demonstrated a withdrawal response as a coping mechanism. The adolescents contributing to Huebner et al's (2007) study talked of the aggravation of having to revert to previous roles on their father's return because their father assumed that everything was the same as before he had deployed. Dandeker et al (2006, p 386) recognised

a similar frustration in wives that their "*invisible contribution*" was not always appreciated by their spouse on his return.

Huebner et al (2007) acknowledged that the adolescents in his study had to cope with two opposing potential realities- their father's death or his return. Not knowing which to prepare for created a confusing range and conflict of emotions, particularly if they perceived that their father had a higher than anticipated risk of serious injury or death. Although Huebner et al (2007) based their investigation on the impact of deployment on adolescents, their study provides an insight into the impact of deployment, and the feelings of loss which entail, that might affect the spouses of those deployed also.

Huebner et al (2007, p 112) acknowledged that military separation is an example of *"ambiguous loss"* for the family left at home. It is "*ambiguous*" as the whereabouts or health status (i.e. whether dead or alive) of the deployed loved one is not known. As Huebner et al (2007) pointed out, even if the family left at home have just spoken to their deployed loved one, and have just been reassured that he is safe, there is nothing to guarantee that he will not be injured or killed shortly afterwards. Huebner et al (2007) acknowledged the limited opportunities for families to communicate with their spouses who are deployed in a dangerous environment, makes it difficult for the partner left at home to cope. Huebner et al (2007) drew on Boss's work (1999, 2002, 2004, 2006) and definition of ambiguous loss to explain the findings in their study. Boss's (2006, p 251) defined ambiguous loss as *"the painful loss that is coupled with a lack of closure"*. As Huebner et al (2007) confirmed, understanding the theoretical framework of ambiguous loss provides an important insight as to why military enforced separation has such an impact on military families and why deployment is so emotionally challenging for the family left at home. Huebner et al (2007) supported Boss's view (2006, p 251) that deployment generates such uncertainty that it creates a barrier to coping as it "*freezes the grief process, blocks coping processes and makes closure impossible*". Huebner et al (2007) recognised that families are not certain whether or not they will be reunited, but if they are, they understand that the dynamics of their relationship might have changed during the deployment.

Dandeker et al (2006) and Fitzsimons and Krause-Parello (2009) acknowledged that such deterioration was exhibited differently depending on the age of the child, from bed wetting in younger children to displays of aggression in older children. Fitzsimons and Krause-Parello (2009) in their review highlighted the benefit of children getting a pet as a substitute attachment figure in their father's absence.

This was particularly apparent if soldiers had their pre-deployment leave curtailed, leaving them with less quality time with their family prior to deployment than they had expected. This observation is important as it may affect the children's health during the time of separation and increase the need for the mother to consult a health professional.

Ryan-Wenger (2002) recommended that parents should encourage children to talk about their greatest fears regarding the death of a parent during deployment. As had been raised in Section 2.3.1, Clifton (2007) identified that if children were not encouraged to express their fears about death, their anxiety may be manifested in physical symptoms just as relocation anxiety had been. Both studies highlight that health professionals should explore the parent's circumstances and question how the parents are coping during any consultations with their children, regardless of the symptoms that precipitated the decision to seek a health professional's advice.

2.3.3 Coping strategies

The need for 'coping' was a common theme within the military literature. However, none of the military literature identified what the term 'coping' meant. Exploring the features of "*Military Family Syndrome*" (Section 2.3.1) showed the importance of developing a coping strategy to combat the psychological impact of disruption due to relocation and removal from the extended family and military enforced separation. Dandeker et al (2006) suggested that the participants' anxiety levels decreased as the deployment progressed because of the resilience of those that took part. Resilience is important within the context of this study as it gives insight into why one Army mother may cope better with the stresses of Army life than another. As Giles (2005) pointed out, a mother's ability to cope affects the decisions that she makes when her child is unwell. Similar to LaGrone (1978), Giles (2005) concluded that non-serving mothers feared that their husband's superiors would be informed that they were struggling to cope and that this could potentially detrimental to their husband's career. Fernandez-Pol (1988) acknowledged that Army wives, particularly officers' wives, under reported symptoms of stress for this reason. She confirmed that Army families had a need for a coping strategy to combat the psychological disruption caused by the impact of relocation.

Both the US and British military literature identified a range of positive and negative coping strategies to combat the stresses of military life. While Dandeker et al (2006) and Davis et al (2011) established that Army wives used various positive ways to cope with deployment, unfortunately, Morrison (1981), Vincenti (1990), Ryan-Wenger (2002) and Clifton (2007) identified that the pressures of deployment resulted in detrimental behaviour. Morrison (1981) and Ryan-Wenger (2002) found

that some serving fathers became alcoholics, Vincenti (1990) warned clinicians to be alert for signs of alcohol abuse in their military patients. Clifton (2007) acknowledged that some children's behaviour deteriorated and they became disruptive. Fitzsimons and Krause-Parello (2009, p 45) recognised that during times of uncertainty and stress, such as during the period of deployment, coping mechanisms in children are *"immobilised"*. This may explain why Clifton (2007) and Ryan-Wenger (2002) identified that military children were more likely to bite their nails or "*pick a fight*" (Ryan-Wenger 2002, p 249, Clifton 2007, p 154) or "*lash out"* (Huebner et al 2007, p 118). Fitzsimons and Krause-Parello (2009) suggested that pets boost a child's ability to cope during times of deployment as they can act as an important attachment figure in their father's absence.

2.3.4 Summary of the features of Army life

Both British and US military literature provided strong and consistent evidence that military life created considerable challenges for Army parents because of the disruption it caused military families, particularly frequent mobility and military enforced separation. The similarity between the findings of both British and US literature demonstrates the value of considering literature from the US, despite the apparent differences in deployment frequency and tour length.

Disruption was largely and persistently viewed in terms of the frequency of moving home and the impact that frequent mobility had on the family (Morrison 1981; Fernandez-Pol 1988; Vincenti 1990; Giles 2005), particularly as relocation could occur any time from 15 months for British families (Vincenti 1990) to two years for those from the US (LaGrone 1978). Disruption impacted on the Army family by the isolation it caused (Fernandez-Pol 1988; Giles 2005), largely because of living away from extended family and moving away from friends (Morrison 1981; Vincenti 1990; Clifton 2007). It was prevalent within the military literature that deployment had a major emotional impact on the wife left at home and forced Army mothers to become lone parents for many months at a time (Blount et al 1992, Ryan-Wenger 2002, Dandeker et al 2006, Huebner et al 2007 and Davis et al 2011). The family left at home had to cope with ambiguous loss and fear that their serving loved one might be killed or seriously injured (Huebner et al 2007), which challenged the ability of Army wives to cope (Giles 2005).

Frequent mobility forced parents to live away from their extended family, and as Giles (2005) highlighted, increased their emotional vulnerability as a result. Giles (2005) in particular, acknowledged that a mother's emotional vulnerability might impact on her ability to make decisions without professional help when her child was unwell. However, many studies (LaGrone 1978; Morrison 1981; Fernandez-Pol

1988; Giles 2005) included participants who suffered from mental illness. Therefore, some of the conclusions of emotional vulnerability must be viewed with caution. Dandeker et al's (2006) findings demonstrated this, as contrary to Giles's (2005) findings, they deduced that the Army wives in their study, who were not known to have suffered mental health problems, became more mentally robust as the deployment progressed. Consequently, the evidence of the extent to which certain features of Army life (in particular frequent mobility and military enforced separation) increase the emotional vulnerability of Army mothers was scanty and warrants further exploration, particularly for Army mothers not known to suffer mental health problems. This would build on LaGrone's (1978) Morrison (1981), Fernandez-Pol (1988), Giles's (2005) and Dandeker et al's (2006) work.

It is noteworthy that the military literature focused on the impact of military enforced separation due to deployment. The evidence was sparse regarding the impact of other forms of military enforced separation, such as training exercises or military courses. There was an assumption within the military literature that deployment was an extreme type of military enforced separation. Also, it was more dangerous than military training, lasted for a greater length of time and was a time when emotions were likely to be at their most intense and raw. However, in reality, as the Ministry of Defence (2009; 2010a) pointed out, soldiers can be away training for many months, during which time communication can be difficult and they are still at risk of serious or fatal injury. Of the 209 British regular Army serving personnel who died in 2009, 99 were killed in hostile action in Iraq and Afghanistan while the remainder died from accidents elsewhere (Defence Analytical Services and Advice 2010, p 110). Only statistics involving hostile action seem to gain media attention. Therefore, further exploration is needed to determine whether other causes of military enforced separation, such as training exercises, have a similar psychological impact on the mother left at home.

There was strong evidence to suggest that ensuring and reassuring participants that confidentially will be maintained is vital for military participants who are taking part in military studies. This can have an impact on recruitment (Ryan-Wenger 2002). LaGrone (1978), Giles (2005), Dandeker et al (2006) and Clifton (2007) all identified that their participants were concerned that confidentiality would not be upheld and that any criticism which they made of the British Army might result in some form of retribution from their husband's superiors.

There was a common assumption within the military literature that couples and parents were married and not co-habiting as partners. This may be because only

married couples or those in a civil partnerships are entitled to live in subsidised military married accommodation (Ministry of Defence 2011b). The descriptor "*Army wife*" is a generic term uniformly used in both the military literature from the UK and the US and appears to describe the female spouse of a serving officer or soldier regardless of whether or not the spouse is a mother. This indicates that Army wives may identify themselves as belonging to a specific group.

The need to 'cope' was a recurrent key theme throughout the military literature and a requisite of being an "*Army wife*". Fitzsimons and Krause-Parello (2009) and Davis et al (2011) highlighted the need for 'resilience' in order to 'cope', although what constituted 'resilience' and 'coping' was not defined within the military literature and warrants further exploration. In fact, Huebner et al (2007) were the only military researchers to explore a theoretical concept (that of ambiguous loss) in detail to explain their findings.

A sense of loss caused by deployment was a prevalent theme in several of the studies from both the UK (such as Dandeker et al 2006) and the USA (such as Huebner et al 2007; Fitzsimons and Krause-Parello 2009; Davis et al 2011). The view that deployment has several stages was consistent within the military literature, regardless whether the research originated from the US or the UK. The way each stage affects the family left at home emotionally is well reported by Blount et al (1992); Giles (2005), Dandeker et al (2006), Fitzsimons and Krause-Parello (2009), Ministry of Defence (2009) Giles (2005) and Davis et al (2011). Fitzsimons and Krause-Parello (2009) from the US viewed deployment as a linear process while Giles (2005) viewed it to be a cyclical process within the British Army. Giles (2005) and Dandeker et al (2006) ascertained that Unit Welfare Officers played a crucial role in reducing the isolation and loneliness felt by Army wives and that there were inconsistencies in the welfare support provided to families from Regiments and families that were part of a Corps. This confirms that the impact of being part of a Corps, opposed to a Regiment, need to be investigated further.

There was a strong suggestion in the literature that Army parents belong to a distinct group who have specific psychological needs. LaGrone (1978, p 1041) provided evidence of this by proposing that military families lived within *"the military's rigid, autocratic system"*, and as a result, Army families could be seen to be suffering from "*Military Family Syndrome*". The *"peculiarities of Army life"* that Vincenti (1990, p 78) recognised and the increased emotional vulnerability of Army wives to which Giles (2005) referred support this notion also. Military enforced separation and the disruption resulting from frequent mobility, were some of the

"*peculiarities of Army life*" which Vincenti (1990, p 78) deduced contributed to the "*turbulence*" of Army life. Vincenti (1990) ascertained that Army families were a minority group because of the impact that frequent mobility had upon them. However, there is no suggestion in any of the other military papers that this is supported. The literature suggests that Army mothers might need greater reassurance when their child is unwell than their civilian counterparts.

In updating the literature review, a further 11 papers were retrieved from the US Army literature that were published in 2010. Some of these papers were discussion papers in non-scholarly journals rather than literature reviews or primary research, while others had such poor study design or bias that their findings could not be relied upon or generalised to the British Army. Therefore, none met the criteria for this review in terms of rigour or trustworthiness and so could not be included. However, the focus of these studies demonstrates the high level of anxiety that the present conflict in Afghanistan is causing to military families left at home. It confirms also the desire of reporters to present largely anecdotal accounts of the impact of the present deployment to Afghanistan on the parent carer left at home and their children within the US Army.

This section has explored the evidence in the literature regarding the features of Army life. Giles (2005) concluded that Army life might have an impact on the psychological state of the Army mother, which in turn might affect her decision-making when her child is unwell. However, the paucity of evidence regarding the process of decision-making that Army parents undertake when their child is unwell necessitates reviewing the civilian literature. This literature is reviewed in the following section to give insight into a mother's help-seeking behaviour and the features that influence a mother's decision to consult a health professional that may be applicable to Army parents. While it is acknowledged that some of these studies (such as LaGrone 1978) lacked clarity in their methodological detail, they were still able to provide vital insights into the features of Army life and how these features affected Army parents.

While the literature focuses on disruption in terms of frequent mobility, only Dandeker et al (2006) identifies disruption in terms of the difficulty in planning daily family life. Such findings are extremely relevant during the present military climate in which serious injuries and fatalities to troops can be a daily occurrence in Afghanistan. Frequency of mobility and the feelings of isolation that it creates are likely to remain a major feature of Army life for the near future.

In summary, the evidence within the military literature strongly suggests that disruption and military enforced separation are two distinct but inter-linked features that appear to be intrinsic to Army life. While some of the papers have some methodological weaknesses (for example, Davis et al 2011 used convenience and snowball sampling), the papers reviewed consistently confirmed that both aspects of Army life have a major impact upon mothers living within an Army environment. There was a widespread assumption that deployment had a greater impact on Army mothers than other forms of military enforced separation. Overall the military literature gave reliable evidence that Army life has a considerable impact on the mothers within its population. Giles (2005) was the only paper that indicated that Army life impacts on a mother's help seeking behaviour. A lack of exploratory qualitative research highlights the need for an in-depth exploration of the impact of Army life and how it influences a mother's decision-making.

2.4 Help-seeking behaviour and the decision to consult

Many factors influence whether a mother perceives that she can manage her child's illness or injury herself or needs to seek help from a health professional (Moll van Charante et al 2008). Influencing factors include a mother's own beliefs, her attitude towards health (Meyer-Weitz et al 2000a; Plass et al 2005), whether she is a lone parent or supported by a partner (Shipman et al 1997a), the child's presenting symptoms (Kai 1996a; Shipman et al 1997b) and the subtle changes in her child's behaviour (Callery 1997; Neill 2000). Other factors considered are, a perceived accessibility of services (O'Cathain et al 2007), previous experience of out-of-hours services (Philips et al 2010) and also previous level of satisfaction with health services (Rajpar et al 2000).

According to the Department of Health (2007), a child under five years old is treated by their GP about six times a year on average, but once they reach school age, this reduces to a similar attendance rate by adults of about two to three times a year. Between 59 and 99 per cent of all episodes of acute childhood illness are thought to be managed at home by mothers without seeking medical help (Neill 2000). Evidence suggests that only one in 37 symptoms is reported to the GP (Scrambler and Scrambler 1984; Campbell and Roland 1996), a phenomenon first termed by Last (1963, p 31) as the "*illness iceberg*". Despite this, consultations concerning children under five years old make up a large percentage of the calls to GPs during the out-of-hours period, with 17 per cent of calls regarding children under four years of age (Turnbull et al 2010).

Many studies reflect the heightened anxiety felt by mothers when consulting about their child (such as Hopton et al 1996; Houston and Pickering 2000; Turnbull et al

2010). As a result, it is difficult to obtain an accurate record of the reasoning process that mothers went through prior to deciding to consult. As Cunningham-Burley et al (2006) pointed out, parents are recalling an event in retrospect and are likely to have gone through a process of rationalisation after they have accessed help. Additionally, as Hugenholtz et al (2009) acknowledged, they have witnessed whether the treatment has been effective or not.

Hopton et al (1996), Kai (1996b) and Shipman and Dale (1999) raised the possibility of a range of factors that could lead to parents deciding to contact a health care professional in addition to the symptoms exhibited by the child. Hopton et al (1996) investigated patients' accounts of calling the doctor during the out-of-hours period. They interviewed 46 study participants, 23 parents who had contacted the out-of-hours service regarding their child and 23 patients who had called for themselves. The findings from both parent and patient groups were the same, which suggests that reviewing the literature on patients' help-seeking behaviour and decision to consult, can increase the understanding of the issues that influence parents' decisions when their children are unwell.

Deputising services for out-of-hours care are almost uniformly used in the Netherlands (van Uden et al 2005), Denmark (Christensen and Olesen 1998; Christensen et al 2004), Belgium (Philips et al 2010) and Norway (Zakariassen et al 2007; Hansen et al 2009) as well as the UK (Richards et al 2007; Garratt et al 2010). Therefore, studies from these countries have been included as they give insight into a mother's help-seeking behaviour that is applicable to this study.

Mothers' perceptions of the health services available to them will have a major impact on the decisions that they make (Wensing and Elwyn 2003; Philips et al 2010). Numerous studies (such as Prince and Worth 1992; Shipman et al 1997a; Shipman et al 1997b; Rajpar et al 2000; Foster et al 2003; Hendry et al 2005; Fry 2009) have confirmed that mothers viewed out-of-hours care to be appropriate for minor illnesses and the ED appropriate for injury or illnesses that might require hospital admission. This review includes studies that indicate the features which impact on the decisions that mothers make when their child is unwell during the out-of-hours period, irrespective of the service they accessed.

2.4.1 Lone parents

Section 2.3.2 identified that Army mothers consider themselves to be lone parents when their husbands deploy, during which time they may be emotionally vulnerable. With such a paucity of military literature, it has been necessary to explore the civilian literature to gain an understanding of the impact that being a

lone parent has on a mother's help-seeking behaviour. Shipman and Dale (1999) undertook a qualitative exploratory study to compare perceptions of urgency and need from the perspective of both the GP and the patient. Sixty six GPs and 98 patients from 25 general practices were interviewed. This study is significant as it was the first study to explore patients' decision-making and their use of out-of-hours services from the perspective of both GPs and patients simultaneously. It demonstrated the difference in perceptions between the GP and patient as to why patients contacted out-of-hours services and what they expected from the consultation. This study acknowledged also that being a lone parent impacted on the decisions that a parent made. Shipman and Dale (1999) concluded that lone parents, without family or friends nearby to support them, were more likely to seek medical aid during the out-of-hours period when their child was unwell than if they were well supported by family and friends with whom they could share the decision-making. Shipman and Dale (1999) ascertained that being alone increased levels of parental anxiety and led to a reduced ability to cope, making the need to seek help more urgent. The findings of Shipman and Dale (1999) suggested that Army mothers may be more likely to consult out-of-hours services during times of military enforced separation than when their serving partner is at home and able to contribute to the decision-making process.

A lack of evidence regarding the decision-making of lone parents, a factor also noted by Brown et al (2008), has necessitated a review of the literature regarding lone parenting generally. A review of the literature made it clear that terminology is important. As Buck et al (2004, p 253) confirmed, a *'lone'* parent has no partner with whom to share childcare duties, while the term 's*ingle*' parent reflects the individual's marital status but acknowledges that there may be a co-habiting partner available for support. Consequently, the searching strategy focused on the term 'lone parent'.

According to the last national Census in 2001, the number of dependant children living in a lone parent family has tripled in civilian society in the last 30 years, with one in five children living with a lone parent who is normally the mother (Office for National Statistics 2002). The stress associated with becoming a lone parent is also thought to have short and long-term health consequences because of the resulting social and emotional turmoil it creates (Benzeval 1998). Buck et al (2004) surveyed a representative sample of 5,611 participants from England and Wales, of which 223 were lone parents. Buck et al (2004) compared the demographics of lone parents who had dependant children with those of couples who had dependant children. They concluded that lone parents had less opportunity for employment

due to a lack of childcare and had greater feelings of isolation because they did not have a partner with whom they could share childcare responsibilities. While they identified a diversity of demographics, most were female, living in rented accommodation, economically inactive and 52 per cent did not have access to their own transport (compared to seven per cent of the partnered group). These demographics reflect the situation of many Army wives during times of deployment and so explain the feelings of isolation and loneliness expressed by the Army wives in Giles's study (2005), many of whom did not have access to transport either.

Other literature related to lone parenting discussed health status rather than decision-making and concluded that lone parents suffer increased social deprivation and have poorer health status than the general population as a result (Benzeval 1998; Spencer 2005; Westin and Westerling 2006). However, this literature is much less relevant to this study, as Army parents have a guaranteed income and access to financial benefits such as subsidised accommodation and subsidised private school education for their children. Given the limited evidence regarding decision-making by lone parents and relevance to this study, it is necessary to review the general literature regarding the help-seeking behaviour of mothers generally.

2.4.2 Parent's own beliefs and attitude towards health

A mother's beliefs and attitude towards health influences her health behaviour and determines whether she treats herself and her children or consults family, friends or a health professional for help and advice (Meyer-Weitz et al 2000a; Plass et al 2005). This explains why some individuals seek help and others do not (Shaw et al 2001). Gulliford et al (2002) identified that individuals have to ascertain that a service is appropriate before they access it, regardless of the symptoms that cause them to need it.

Mechanic (1964, p 445) explored the decision to consult in terms of "*illness behaviour*" which he defined as the way that "*given symptoms may be differentially perceived, evaluated and acted (or not acted) upon by different kinds of persons*". Mechanic (1964) concluded that a mother's motivation to seek help or not originated from her own view of health and illness, which she has derived from her own upbringing, her level of education, her level of stress, and her family's definition of what constituted health. Mechanic (1964) recognised that mothers who were less educated tended to be less concerned about detecting illness in their children. He concluded that mothers were much more likely to contact the doctor concerning their child's health than their own and reported more illness symptoms in both themselves and their children when they were "*under stress*".

Unfortunately, Mechanic (1964) could not conclude from his data whether these children had a worse health status than others, which may have influenced their mothers to consult. His methods had some limitations, for example, some variables were not taken into account in the analysis, such as the health attitude of the family or the relationship between the mother and the child. Nevertheless, this study was one of the earliest that recognised that the mother's health attitude and behaviour influenced whether or not she accessed health services when her child was unwell. It highlighted the importance of health providers considering the mother's social circumstances, personality, behaviour and psychological state when treating her child.

Zola (1973) developed Mechanic's (1964) work and explored the factors that caused an individual to seek medical aid and so change their status from being a "*person to a patient*". She acknowledged that patients' decision to consult was influenced by their tolerance of a situation or their assumption of the implication of their symptoms, rather than the symptoms themselves, a view supported in later studies by Gulliford et al (2002) and Morgan (2003). Zola (1973) suggested that an individual's psychological state or stress level has a major impact on whether they seek or delay seeking medical help for themselves or their children. Hopton et al (1996) supported Zola's (1973) work and also identified that mothers sought medical help for themselves only to help them recover quickly so that they would be well enough to look after their children or because they were concerned that their illness would spread to their other children. Reviewing Mechanic's (1964) and Zola's (1973) work is particularly important as it is very relevant to this study in which mothers may be undergoing additional emotional pressures due to the "*peculiarities of Army life"* (Vincenti 1990, p 78) such as military enforced separation.

The military literature discussed in Section 2.3.3 raised the importance of coping strategies while Section 2.4.1 raised the challenges of being a lone parent. While Neil (2000) and Kai (1996a) did not investigate the impact of being a lone parent on decision-making, they both acknowledged that parents accessed their GP less often when they had a small 'lay network' of support such as family and friends. In his framework for the study of coping, Shaw (1999) confirmed that social support plays an integral part in the coping process, whether it is perceived or actual.

While the term 'coping strategy' was not defined within the military literature, the civilian theorist Leventhal et al (1998, p 722) believed it to be "*the cognitive and behavioural actions we take (or do not take) to enhance health and prevent, treat*

(i.e. cure and control) and rehabilitate from illness". They identified that coping has two facets- problem focused and emotional focused, and could change over time depending on the circumstances and the individual's personality. Furthering Leventhal et al's work (1967; 1983; 1998), Shaw (1999) perceived that the severity of an illness and the interpretation of symptoms are influenced by the situation of the parent. A child's illness can be seen as a greater health threat by the mother if the mother is enduring a stressful situation herself. He confirmed that while mothers have an overwhelming need to do what is best for their child, they do not want to waste a doctor's time by accessing services unnecessarily. Shaw (1999, p 1248) hypothesized that an individual's personal interpretation of illness and their assumptions about its likely outcome had an impact also, which he termed "*illness representations and attributions*". Both Shaw (1999) and Leventhal et al (2003) concluded that individuals (undergo a five stage cognitive and emotional process to produce an illness representation, this could include Army mothers also. For example if a mother suspects meningitis in her child, she may undergo the illness representation depicted in Table 2.2.

Table 2-2   A five stage illness representation

Cognitive process	Interpretation
Identity of the illness such as signs and symptoms	High temperature and a rash
Time line	Child could die in a few hours
Consequences	Child may die if no treatment is given
Cause	Possibly bacterial meningitis
Sense of control	Whether can be treated and cured with antibiotics if caught quickly enough

From Shaw's (1999) work, one can hypothesize that the greater the social network and the more able a mother feels to seek help from family and friends, the less likely she is to actively seek professional help. Also, as Mattlin et al (1990) and Shaw (1999) acknowledged, certain situations are more likely than others to elicit certain types of coping. This indicates that the impact of aspects of Army life such as military enforced separation (the situation) and the fear and vulnerability it creates (which is influenced by the individual's personality) may make Army mothers more emotionally vulnerable. According to Shaw's (1999) work, this increases the likelihood of them seeking professional help when their child is unwell.

Leach et al (1993) undertook a survey of 174 Army mothers of children who were between three to six years old. They used a specially designed general health questionnaire that had been previously piloted in a military GP practice nearby. The general health questionnaire assessed the level of anxiety and depression that was of recent origin. Leach et al's (1993) results demonstrated that the higher the general health questionnaire score and therefore the greater the mother's level of

anxiety or depression, the more likely she was to consult a GP when her child was unwell. These results illustrate that the psychological state of the mother influenced the frequency of attendance for the child as much as the severity of the child's illness, irrespective of the child's symptoms. The questionnaire gave insight into how the psychological state of an Army mother affected her decisions to seek help when her child was unwell, despite the lack of information as to whether these mothers had any underlying mental health disorders, or if they had a partner or were lone parents. Interestingly Leach et al (1993) did not refer to Mechanic's (1964) work.

Vedsted et al (2001a, p 122) confirmed that patients who have greater levels of psychological stress are more likely to become "*frequent attenders*". While "*frequent attenders*" are a relatively small group as Neal et al (1998) and Turnbull (2008) recognised, they cause concern to health providers due to their impact on service use and workload, particularly as those with self-limiting conditions can overwhelm limited health services who wish to prioritize emergency and urgent treatment to those who need it. At the opposite extreme, as Trajanovska et al (2010).pointed out, some mothers' perceptions of illness had caused them to delay seeking treatment with potentially disastrous consequences, as in some cases children had died from meningitis

2.4.3 Assessment of the unwell child

Kai (1996b) studied parents attending an inner city parent and toddler group. He held ten focus groups with 63 parents and undertook interviews with 32 parents of pre-school children. Like Giles (2005), he utilised the crèche facilities, which aided participation and raised an important practicality to consider when recruiting the parents of young children to a study. Hopton et al (1996) used the unorthodox method of random sampling for a qualitative study, rather than purposively sampling to ensure that there was the same number of participants in each group. They did not comment about potentially reaching theoretical saturation. Despite this, the process of data collection and analysis used enables confidence that the findings are trustworthy.

The studies by Hopton et al (1996) and Kai (1996b) found that parents reached conclusions about the seriousness of an illness by comparing their child's symptoms to the state which they ascertained was normal or abnormal for their child; a raised temperature that they could not control caused considerable concern. Kai (1996b) concluded that parents assessed what was normal for their child by gauging how the symptoms were affecting the child's 'normal behaviour' such as eating and drinking, as well as by evaluating the implications of the

symptoms themselves. Kai's (1996b) findings were supported also in a later study by Broadhurst (2003).

Kai (1996b) recognised that parents constantly monitored their child's temperature to try to make sense of the illness, as they needed to feel in control of their child's symptoms. The less the mother could control the symptoms and relieve her child's suffering, the greater the need to transfer responsibility to a health professional and receive reassurance that she was giving her child the appropriate treatment (Kai 1996b; Houston and Pickering 2000). Mothers talked of their fear of missing a serious diagnosis like meningitis. They used emotive language, such as being *"terrified"* that their child would die Kai (1996b, p 985). A fear of meningitis and that their child could die is a common anxiety experienced by parents and is a recurrent theme in many other studies (such as Kallestrup and Bro 2003; Hendry et al 2005; Thompson et al 2009). Kai (1996b) acknowledged that a media campaign to educate parents about meningitis has done little to reduce their anxiety. Grundy-Wheeler (1991) and Crocetti et al (2001) pointed out the importance of educating mothers correctly, to enable them to be better informed but not made unnecessarily anxious. There is no evidence that the Department of Health and the Meningitis Awareness Foundation's recent campaign and leaflet stating that "*Meningitis and septicaemia are very dangerous and can kill in hours*" (Meningitis Research Foundation 2009) has reassured parents. This is compounded by the fact that rashes in children are common, normally self-limiting and innocuous as Hugenholtz et al (2009) pointed out.

Leading on from Kai's (1996b) work, Shipman and Dale's (1999, p 269) study demonstrated the reluctance displayed by some GPs to provide what they perceived as *"unnecessary"* consultations for self-limiting symptoms. As Meyer-Weitz et al (2000b) pointed out, such attitudes make parents frustrated as they feel that they are not being taken seriously. Shipman and Dale (1999) concluded that patients' anxiety levels seemed to increase in the middle of the night, as it was a time when usual sources of support were less accessible and when they were most likely to be exhausted. This meant that the out-of-hours period was a critical time, when mothers were most likely to interpret symptoms as more serious than they actually were. This highlights the impact that a loss of emotional support and increased levels of fatigue have on decision-making. Kallestrup and Bro (2003) interviewed 146 parents who sought medical advice. As Hopton et al (1996) had confirmed seven years earlier, Kallestrup and Bro (2003) concluded that a parent's priority was to have a diagnosis to ease their child's suffering, irrespective of the time of day that the symptoms occurred. Parents' explanations did not differ nor their seeking

help alter depending on whether it was the day or night. Forty nine per cent had sought advice because they perceived that their child's condition was out of their control, 17 per cent feared the presence of a serious disease, and 34 per cent sought symptom relief and wanted to be instructed on what course of action was best for their child.

Both Cornford et al (1993) and Kai (1996b) acknowledged that a child's cough created great anxiety in parents. Cornford et al (1993) interviewed 30 mothers and established that generally mothers feared that coughing would cause permanent damage to their child's lungs or would cause them to die through choking or an asthma attack. According to Bruijnzeels et al (1998), parents attending their GP because of their child's cough were so common that parents' attendance rates due to this condition have been used to measure children's GP consultation rates. Chang et al (2006) undertook a systematic review to explore how childhood cough is defined and treated by GPs. They reviewed 50 papers from which they concluded that GPs viewed childhood cough as a largely self-limiting innocuous symptom of an uncomplicated acute viral respiratory tract infection; they also found that GPs were baffled by the level of parental anxiety that childhood coughs caused. The studies they reviewed confirmed that parents were consulting with their GP more often than necessary because GPs were not acknowledging parents' fears or their need for education to advise them that childhood coughs were normally harmless to children. This raises the importance of reassuring the parent as well as treating the child who is unwell, not only for the benefit of the parent, but also to reduce consultation rates for GPs.

2.4.4 Accessibility of services

Access relates to the concept of the users "*ability or willingness to enter into the health care system*" (Penchansky and Thomas 1981, p 128). Therefore, it requires both the provider to supply a service and the user to wish to use it. Aday and Andersen (1981, p 5) defined access as "*those dimensions which describe the potential and actual access of a given population group to the care delivery system*". Aday and Andersen (1974) developed a model to demonstrate the factors that affected an individual's ability to access a health service. They suggested that potential access to a service was influenced by health policy directives, the characteristics of the health care system and of the service provider (such as its location), and the demographics of the population at risk (such as its age and health status). Aday and Andersen (1974, p 209, 1981, p 15) stated that utilisation is an "*objective*" indicator and satisfaction is a "*subjective"* indicator of actual or "*realised"* access. They believed that actual or "*realised*" access is influenced by the expectations and needs of the population who the service is provided for, which

they called *"predisposing"*, *"enabling"* and *"need"* factors (Aday and Andersen 1981, p 15). They concluded that individuals make *"trade-offs"* such as weighing up convenience against gaining (accessing) treatment (Aday and Andersen (1981, p 7). They proposed that individuals' predisposing characteristics (such as age) influenced how frequently they accessed a service. Aday and Andersen (1981, p 15) identified *"enabling indicators"* to be the factors that influenced how easy it is to access a service (such as access to an appointment or distance of home from service provision). The need refers to the individuals' health status and their requirement for health care. Even though this is a US model of care where medical care is not free at point of access, as Goddard and Smith (2001) acknowledged it demonstrates that access to out-of-hours care is a multi-dimensional concept based on many factors. For example, commissioners of service provision might conclude that a centralised system is financially more efficient than a local one. However, this may be unacceptable to mothers whose child is unwell, as they are unable to utilise the facility because of the travelling distance involved in accessing the service, or in the language of Aday and Andersen (1981, p 15) *"potential access"* is not converted into *"realised access"*.

Although health care is free at the point of delivery in the UK (Department of Health 2010a), the decision to access care may be influenced by other hidden costs in financial, organisational, social and cultural considerations that limit utilisation (Gulliford et al 2002). Therefore, access measured in terms of utilisation is dependent on the affordability, physical accessibility and acceptability of services (Gulliford et al 2002). Despite the Government's commitment, as Field and Briggs (2001) endorsed, access to appropriate primary health care provision does not always fulfil the needs of local communities and individuals. Rural communities are particularly disadvantaged regardless of their level of need (Farmer et al 2006).

Aday and Andersen's (1981) framework considered access as an all-embracing concept, whereas most of the evidence since has focused on investigating a particular aspect of access to health care. These features have included:
  1) Equity of access (Goddard and Smith 2001).
  2) The options for care (such as ED or out-of-hours services) (O'Cathain et al 2008).
  3) The impact of the geographical location of services (Campbell et al 2006; Turnbull et al 2008; Turnbull et al 2010).
  4) Transport availability (Jordan et al 2004).
  5) Method of access (i.e. face-to-face or via the telephone) (Lattimer et al 1998; Bunn et al 2004; Munro et al 2005).

6) Speed of access (Gerard et al 2006; Richards et al 2007).

7) Location of consultation (i.e. home visit or GP surgery) (Salisbury et al 2000; Farmer et al 2006).

8) The type of health professional (i.e. nurse or doctor) (Lattimer et al 2000).

9) Satisfaction with services (McKinley et al 2002).

Understanding the issues related to access is important as it affects the utilisation of out-of-hours services by Army parents when their children are unwell.

Equity of access

Equity of access means that equal services should be made available to patients with the same needs regardless of their demographics (Goddard and Smith 2001). The principle of equity of health care has been endorsed by the World Health Organisation, which stipulated that health systems should ensure that their policies do not intentionally increase socioeconomic and health inequity (World Health Organisation 2009). In the UK, the Department of Health is committed to giving patients choice and straightforward equal access to health services (Department of Health 2010b; 2011), allocating funding to PCTs to ensure equity of provision (World Health Organisation 2009).

Options for care

Much of the health care in the UK is provided with less than 24-hours' notice as 'unscheduled' or 'urgent' care (O'Cathain et al 2007). Parents may access a variety of services for the same illness episode (Payne et al 2001; O'Cathain et al 2007; Fry 2009), for example, they might call their out-of-hours clinic for advice, the staff of whom may direct them to ED via ambulance. GP co-operatives remain the most common model of out-of-hours clinics and are often located within emergency care centres a distance from those accessing them (Munro et al 2003). Shipman et al (1997b) interviewed 82 participants to investigate why parents and patients decided to access ED rather than the out-of-hours service. Their study took place before Walk-In-Centres or Minor-Injury-Units were established, but nevertheless, provides a key insight into why mothers access different health services. Most accessed their GPs for digestive, respiratory and viral or non-specific complaints while acknowledging that soft tissue and skeletal injuries justified attendance at ED. Of those who attended ED, 39 per cent had spoken to their GP before attending, nine per cent had spoken to their family, six per cent had contacted friends, and two per cent had made contact with others. Any 'others' were not defined but 60 per cent had not contacted anyone else for help. Fifty six per cent of those interviewed said that they would have contacted their own GP instead of ED if their surgery had been

open after working hours. Their findings demonstrated that the participants'
choice of attendance was influenced by their perceived lack of access to a GP rather
than a need for emergency treatment. This was particularly the case for parents
who were attending with their sick child who was ten years old or younger, the
majority of whom had contacted a GP rather than ED. Shipman et al's (1997b) study
acknowledged that a large percentage of participants had sought help without
consulting anyone else first. The study did not explore the effect that being a lone
parent had on shared decision-making, or if parents who had shared their decision-
making with a partner categorised this process as 'consulting' someone else.

Chalder et al (2007) concluded from their quantitative survey that there was little
evidence to support the co-location of Walk-In-Centres next to an ED as some
parents were not even aware of the existence of the Walk-In-Centre and thought
that their child was being treated in ED anyway. This study deduced that Walk-In-
Centres had no impact on patient choice, preference or satisfaction. It also
confirmed that the greatest proportion of participants attending either the Walk-in-
Centre or ED presented with an injury rather than an illness.

Hendry et al (2005) undertook a questionnaire-based survey of 465 children
selected by sampling attendees to ED who had been allocated the lowest triage
category. Sixty per cent of children attended with their mothers alone, while the
majority of the remainder attended with both parents. Twenty per cent of those
attending were from 'single' parent families. Unfortunately, any impact that being a
single or a lone parent had on the parents' decision to attend ED was not noted; or
even whether 'single' referred to lone parent or those of single marital status who
may have been supported by a partner. The results confirmed that 77 per cent
(n=305) of parents had taken third party advice, far more than the 40 per cent that
Shipman et al's (1997b) study had identified, for which no explanation was given.
Thirty seven per cent (n=172) of parents had initiated some form of treatment
before attending ED and the majority of these (76 per cent) attended with an injury
because they felt they could do no more for their child, which supports the findings
of Shipman et al (1997b). Prior to this, Kai (1996b) had concluded that most
parents accessed ED to obtain a second opinion about their child's condition as
they were concerned that their child was not getting better. He identified that many
had already consulted with their GP and had self-referred to ED. The findings did
not acknowledge whether mothers had chosen to access ED as they wished to seek
specialist paediatric treatment, because of their perception of the seriousness of
their child's illness, or due to a lack of confidence in their GP's ability to treat
children. Kai (1996b) confirmed that parents take an active role in the decision-

making process regarding the health of their children; it is also clear that anxiety has a powerful effect on a mothers' decision-making, and that her fear of missing a serious illness drives her to 'play safe' by seeking medical care for what health professionals see as non-urgent childhood illnesses. As Robbins et al (2003) pointed out, no illness is 'minor' in a mother's eyes and the triage category 'minor' can only be applied to an illness in retrospect once the child has recovered.

O'Cathain et al (2008) undertook eight focus groups (n=47) and 13 individual interviews using a purposive sample of patients and parents that had accessed health services for an urgent problem within the previous four weeks. This was to explore views and experiences of the emergency and urgent care system. Their findings indicated that participants were aware of the range of services available to them, but were confused about which service was appropriate to approach. Some accessed ED rather than the out-of-hours service merely because they did not want to disturb their GP (O'Cathain et al 2008). Participants highlighted the importance of being able to secure an appointment during working hours to avoid needing a more urgent one later, as well as wanting to negotiate with the 'gatekeepers' of the service, such as the GP, that their child warranted attendance at ED for treatment. Their perception of GPs as 'gatekeepers' for ED may be incorrect, as other studies (for example, Shipman and Dale 1999; Anthony 2003; Calnan et al 2007 and Fry 2009) highlight that GPs no longer take an active gatekeeper role to reduce attendance at ED. Parents were particularly assertive if treatment was for their child rather than for themselves. Identification of patients' confusion about whether to access ED or the out-of-hours service has been reflected in many previous studies (such as Prince and Worth 1992; Shipman et al 1997a; Shipman et al 1997b; Rajpar et al 2000; Foster et al 2003; Hendry et al 2005 and Fry 2009). However, choice of access was worth exploring again because of the changes in service provision in recent years.

Geographical access

Evidence suggests that the distance which patients must travel to access health services inhibits their use (Jones et al 1998; Jordan et al 2004) and is associated with a number of poor health outcomes, such as higher than expected asthma related deaths (Jones et al 1998) and lower than expected survival rates from cancer (Campbell et al 2000). Campbell et al (2006) confirmed that the greater the distance, the lower the rates of consultation, referred to in the literature as 'distance decay'. However, measuring access in terms of geographical distance does not identify the demographics and health needs of the population and as

Turnbull (2008) pointed out, tells us little about the population distribution and their level of need.

Farmer et al (2006) undertook four focus groups comprising of 32 participants and then interviewed 51 participants from eight purposively selected rural and urban GP practices in Scotland, with the aim of eliciting the differences in decision-making due to location. Farmer et al (2006) argued that those living in rural communities are disadvantaged as Walk-in-Centres and ED are normally located in urban areas, which may be difficult for them to access. They presented the focus group participants with scenarios of various illnesses and asked what they thought they would do in each situation. Holloway and Wheeler (2010) have advised researchers to recognise that what people say that they would do in theory is often different to what they actually do in practice. It would have been useful for Farmer et al (2006) to have included some observations or further interviews with patients in their study design who had actually experienced the scenarios that they had asked them to explore. This would have enabled them to confirm whether what the participants stated that they would do was translated into their actions and behaviour. Farmer et al (2006) concluded that their focus group data highlighted extremes in rural and urban differences, while the interview data allowed greater focus on individual's stories. They did not give any information concerning how the focus group findings were used to develop the interview guide or why focus groups were used as a method at all. Despite this, the study's findings demonstrate that personal beliefs about health played a major part in the decision to access care, irrespective of the geographical setting, and that participants would use previous experience and their own knowledge to diagnose if there was a problem. What is important about this study is that it produced evidence that those living in rural communities undertake a much more complex decision-making process than those from urban areas. As observed by Farmer et al (2006, p 212), parents made "*trade-offs*" and weighed up the options which they considered to be the most appropriate courses of action. These included the distance from home, how easy it would be to get to the clinic, if they would prefer a home visit and whether the doctor would be able to find their house if they did visit them at home. On the other hand, Farmer et al (2006) found that those from urban areas would either call the out-of-hours service for advice, or attend the local ED or call for an ambulance without much deliberation.

Turnbull et al (2008, p 472) took the work by Farmer et al (2006) one stage further by exploring the effect that distance and decreasing urbanisation (which they termed *"rurality"*) had on the rate of out-of-hours usage. They undertook a quantitative analysis of the routinely collected data from 34,229 telephone calls to

one out-of-hours co-operative that served a variety of urban and rural locations. They identified that most of the calls were from patients who lived within five kilometres of their nearest out-of-hours clinic, and observed that the number of calls decreased with increasing distance and lack of urbanisation. Sixty six per cent of calls were from urban areas, with the greatest proportion coming from deprived inner city areas, while only four per cent were from 'isolated dwellings' within rural communities. This was an interesting finding, as telephone access should ensure equality in initial contact, as individuals call from the convenience of their home or mobile telephone, meaning that the distance to their nearest clinic should be irrelevant. Turnbull et al (2010) developed their 2008 work by interviewing eight parents of children who had used the out-of-hours service in order to shed light on the reasons why geographical variation had such an impact. The qualitative analysis suggested that geographical variation was linked to parents' familiarity with using out-of-hours services (notably if they had used it before), the availability of services, the legitimacy of using the service and negotiation about the method of approach (i.e. face-to-face or via the telephone). From a methodological point of view, this demonstrated that using qualitative methods to explore the conclusions from a quantitative study was an effective method to do so.

Turnbull et al's (2010) findings provided further evidence to reinforce the conclusions of Caldwell et al (2004) that the greater the distance from the health care provider the lower the rates of consultation. They demonstrated that parents living more remotely did not access services as frequently as those living in urban areas did. This was despite the study population from rural communities having greater car ownership than those for urban areas and being used to travelling to access all types of services. This study also raised the issue of the inequity of provision as Farmer et al (2006) detected that rural communities had access to fewer GP appointments during working hours and had no paediatrician nearby unlike their adjacent urban community. From reviewing the work of Farmer et al (2006) and Turnbull et al (2008; 2010), it can be concluded that geographical barriers such as distance and lack of urbanisation are important determinants of the tendency of individuals to call the out-of-hours service. In 2010, the Commission for Rural Communities (2010) confirmed that 70 per cent of the national population own a car but that car ownership is greater than the national average within rural communities (between 82 per cent and 88 per cent) and less (38 per cent) for those living within inner cities. Yet, it appears that rural populations use services less even though they have greater access to their own means of transport.

Ease of access

Car ownership does not necessarily mean that a mother has access to a car when needed as it might be in use by other family members, or she may not be able to drive. As Jordan et al (2004) pointed out, even though rural communities have greater car ownership, those who do not have their own means of transport are disadvantaged. This is because those from rural areas have less access to public transport, which places a further burden on groups who have a greater need for health care (such as mothers with young children). O'Donnell et al (1999) assessed how social deprivation affected the use of free transport for patients between their homes and the out-of-hours centres offered by the Glasgow Emergency Medical Service. They found a 60 per cent higher utilisation rate for children and adults from deprived areas, and that patients from deprived areas were four times more likely to use patient transport. This trend was most apparent at night, when there was a sevenfold difference between affluent (under six per cent) and deprived areas (44.4 per cent). While this study assessed deprivation rather than urbanisation, it highlights that a lack of transport might present a barrier to accessing out-of-hours services and raises important questions as to whether Army parents are equally disadvantaged. Indeed, Lovett et al (2002) concluded that those with the least access to personal transport were those who had the highest health needs, especially if they lived where there was no daytime bus service and no community transport. Thirteen per cent of this study population could not reach general medical services by bus in the day; access to public transport at night was even more difficult, if not impossible.

Home visits remain an important feature of primary care in the UK (Aylin et al 1996) and are highly valued by parents (Shipman et al 2000; Shipman et al 2001; Richards et al 2007). The ease of access that home visiting provides ensures that it remains popular, particularly with parents who are living in rural communities where access to a clinic might be difficult because of a lack of transport (Farmer et al 2003). Richards et al (2007) recognised a widespread reluctance among GPs to undertake home visits, which they viewed as a poor use of resources, as they could treat many more patients in their clinic in the time that it took to complete one home visit. As a result, the number of home visits has declined from 63 per cent of calls in the mid-1990s (Heaney and Gorman 1996) to 23.6 per cent by 2000 (Salisbury et al 2000).

Turnbull (2008) confirmed that travelling to the nearest out-of-hours provider with children who are unwell is particularly contentious for parents. Shipman et al (2001) identified the importance of home visits for parents by interviewing them

(n=72) to obtain their views of their expectations and experiences of attending an out-of-hours clinic. Twenty five per cent of those who had received a home visit had requested one because they refused to attend the out-of-hours clinic, perceiving that the barriers to attending the clinic were insurmountable. The barriers cited included the perception that taking children out at night if they were unwell might worsen their condition, not wanting to disrupt the other children and the danger of travelling with a sick child as a lone parent as no one else was available to support their sick child while they were driving. Finding the geographical location of the out-of-hours clinic alone added additional stress. If there was no transport available a home visit would prevent them calling an ambulance unnecessarily (Shipman et al 2001), particularly as access to transport at night can be very limited as Lovett et al (2002) concluded.

Method of access

Consultations during the out-of-hours period are undertaken either face-to-face or via the telephone. The development of NHS Direct resulted in an increase in the use of the telephone for triage (Turnbull et al 2010), with 40 to 50 per cent of consultations managed solely by telephone (Lattimer et al 1998; Leibowitz et al 2003). Access to a telephone is essential as initial contact with out-of-hours care is via telephone to a call handler who determines the best course of treatment. Even though NHS Direct as a service is being discontinued, the telephone will remain an important portal to access its replacement, the NHS 111 service is to be rolled out nationally following its pilot in County Durham and Darlington that began in August 2010 (Bruce 2010).

Bunn et al (2004; 2005) completed a systematic review of nine studies on the effectiveness of telephone consultation and triage on health care use and patient satisfaction. Three of the five studies they reviewed identified a significant decrease in visits to GPs, but two found an increase in return consultations. On average, at least half (range between 25 to 72 per cent) of calls were handled by telephone consultation alone. This systematic review found commonality within the results, as telephone consultation appeared to have the potential to reduce GP workload. Lattimer et al's (1998) study was one of several reviewed by Bunn et al (2004; 2005) and provided the earliest evidence of the impact that nurse telephone triage had on GP workload.

Lattimer et al's (1998) equivalence randomised controlled trial investigated the safety and effectiveness of nurse telephone consultation in out-of-hours care within a study population of patients selected from a 55 member general practice

cooperative serving 97,000 registered patients. Results confirmed that telephone triage was just as safe and effective if undertaken by nurses as GPs. Their process of randomisation and analysis of 14,492 calls concerning 10,134 patients (ten per cent of the population) gives confidence in the wider application of the results. This study also confirmed that not all patients need a consultation face-to-face. This supports Kai's (1996b) conclusion that GPs viewed many face-to-face consultations about children's minor conditions as inappropriate and more suited to a telephone consultation.

Shipman et al (2001) demonstrated that the use of the telephone as a mode for consultation is unpopular with parents. Payne et al (2001) identified this to be because parents were concerned that using the telephone as a means of accessing triage rather than face-to-face contact placed too great an onus on them to give the correct information to the health professional to enable them make a diagnosis. Also, they did not understand how a nurse or doctor could make a correct diagnosis without having seen their child face-to-face.

Although the assessment of return consultations was beyond the scope of Lattimer et al's (1998) study, it raised issues regarding safety, cost, and patient satisfaction that required further investigation. Giesen et al (2007a) took up this challenge and undertook a cross-sectional study to explore the association between negative patient evaluation of nurse telephone consultations and the characteristics of patients and GP Co-operatives. Postal questionnaires were sent to patients (n=2583, 49.3 per cent response rate) from a representative sample of GP Co-operatives across the Netherlands. Patients who had expected a face-to-face consultation or home visit, but had not received one, gave the most critical evaluation of both the accessibility and the nurse telephone consultation. This supported Thompson et al's (2004) conclusion that patients were most satisfied when they received the type of contact they initially requested. Giesen et al (2007a) identified that 22 per cent of parents were not satisfied with the level of reassurance they had received over the telephone, but acknowledged that this may have been because the caller was expecting a doctor rather than a nurse. Unfortunately Giesen et al (2007a) did not provide details regarding time delay, as this could have accounted for some of the negative evaluation. When reviewing these studies it is important to appreciate the context as it may influence the findings or results. For example, the parents in Giesen et al's (2007a) study were telephoning about concerns regarding minor illnesses in their children and not medical or surgical emergencies that may have a different health outcome and achieve different levels of satisfaction. A preference to see a health professional

face-to-face rather than having contact via the telephone impacted on levels of satisfaction also, and is confirmed in other studies (such as Payne et al 2001 and Leibowitz et al 2003).

In Giesen et al's (2007a) study, only two out of the eight GP Cooperatives undertook telephone triage, so the impact of this determinant on the evaluation of the telephone nurse triage needs to be interpreted cautiously. In addition, the 50.7 per cent non-response rate may have biased the results. However, the impact of patient expectation and its relationship with user's assessment of satisfaction with services was an important one and has been reflected in many other studies (such as Avis et al 1997; McKinley et al 2002; Anderson et al 2007; Brink-Muinen et al 2007). For example, Anderson et al's (2007) qualitative analysis of the comments from their survey identified that patients assessed at least seven domains of health care to determine their levels of satisfaction. Domains included access, communication, the personality and demeanour of provider, the quality of medical care processes, care continuity, quality of the health care facilities and interpersonal skills of the administrative and clinical staff (Anderson et al's 2007, p 261).

Since the implementation of the Department of Health document "*Making a difference: strengthening the nursing, midwifery and health visitor contribution to health and health care"* (Department of Health 1999) nurses have become the routine first point of contact for out-of-hours care by means of Walk-In-Centres, NHS Direct and nurse telephone triage (Horrocks et al 2002). The literature cites many reasons for this including cost (Lattimer et al 2000), the need to increase out-of-hours provision because of the skills and expertise of nurses (Horrocks et al 2002), and the ability to maintain out-of-hours provision in light of the reduced number of GPs available as a result of the change to the General Medical Council contract in 2004 (British Medical Association 2010). As a result, nurses potentially substitute for doctors in front line care in both ED and the out-of-hours clinic.

Following on from Lattimer et al's (1998) work, both Horrocks et al (2002) and Laurant et al (2005) undertook systematic reviews to determine whether nurse practitioners could provide care at first point of contact equivalent to doctors in a primary care setting and achieve as good health outcomes for patients. Both reviews concluded, as Lattimer et al (1998) had done, that nurse consultation was as effective as GP consultations. Unfortunately Horrocks et al's (2002) review was limited by the quality of the available observational studies, so they based their results on the randomised control trials, which may have meant that there was evidence that they could not include. The reviewed studies confirm that patients

and mothers were more satisfied with the care they had received from the nurses than the care received from the doctors. This was thought to be because nurses gave them more information and patients felt that the nurses communicated better with them than the doctors had done.

Seale et al (2005) undertook a comparative content analysis of audiotape transcriptions of 18 matched pairs of nurse practitioner and GP consultations, and identified that nurse practitioners spent twice as long with their patients (or parents). Participants spoke of longer communication with the nurses than the doctors, which accounted for patients' increased satisfaction with nurse-led consultations. The study was limited to acute, self-limiting illness about which nurses were confident to give advice; assessing emergency consultations for more serious complaints may have exposed different communication interaction.

Speed of access and causes of delay
Kai (1996b) confirmed that speed of access to a health professional is important to parents, particularly if they are frightened that their child might have a serious illness such as meningitis. Nurse telephone triage has been shown not only to be safe and effective (Lattimer et al 1998), but also to increase the speed of access to advice for mothers, as well as enabling them to gain advice without having to disrupt the rest of the family in the middle of the night (Simpson et al 2000). Simpson et al (2000) undertook a retrospective analysis of calls taken by nurses at a military out-of-hours clinic and concluded that 47 per cent of calls were related to children and 70 per cent of all callers required advice only, enabling them to stay at home.

Campbell et al (2007) concluded that the time delay between making the initial call to the call handler and receiving a call from a nurse or a doctor created anxiety for parents and led to an inappropriate use of services. Three studies (Pooley et al 2003;; Lattimer et al 2005; Richards et al 2007) noted that a delay in receiving a consultation led to increased use of an ambulance, as waiting for a nurse to call back was too stressful for parents in their state of heightened anxiety. Pooley et al (2003) identified that not being informed of the expected delay compounded the stress. However, despite this, Gerard et al (2008) concluded that while speed of access is important to individuals when they want to see a health professional urgently, they are prepared to trade speed for continuity of care if the problem is less urgent. Gerard et al (2008), as well as Caldow et al (2007), concluded also that most people accept a change in the type of health professional with whom they are consulting, providing that they are informed prior to the consultation and receive

adequate information about the nurse's capabilities. These studies support Shipman et al (2000) and Salisbury (2000) earlier work which recognised that satisfaction levels were reduced if individuals saw a nurse when they were expecting to see a doctor. The latter studies (Shipman et al's 2000 and Salisbury 2000) were undertaken before nurse led consultations were well established, all four studies (Shipman et al's 2000; Salisbury 2000; Caldow et al 2007; Gerard et al 2008) demonstrate the importance of keeping patients informed.

2.4.5 Previous experience and satisfaction

Patient satisfaction is a measure of patient perception of the quality of care (McKinley and Roberts 2001). It has increasingly being used to inform models of service delivery (Department of Health 2004b; Campbell et al 2009). Wensing and Elwyn (2003) acknowledged the importance of gaining user's views to ensure service delivery.

Meeting expectations has been shown to predict levels of patient satisfaction (Edwards et al 2009). This is independent of the service type or location of care (McKinley and Roberts 2001; McKinley et al 2002; Thompson et al 2004; Richards et al 2007). The most common reasons given for dissatisfaction cited by parents was that they had to persuade professionals to believe that their child had a serious problem (Callery 1997) and that they were made to feel they were wasting the doctor's time, (Payne et al 2001).

Redsell et al (2007) explored the relationship between an individual's prior expectations and their actual satisfaction with nurse consultations, by interviewing 28 participants prior to their consultation and 19 of the same participants once their consultations were completed. They concluded that patients were satisfied with nurse-led care because they did not know what to expect from a nurse consultation and had held lower expectations of nurse-led than doctor-led care prior to their consultation.

Patient satisfaction has shown to increase once service users have become accustomed to new services (Vedsted et al 2001b; Campbell et al 2006). Once parents have used an out-of-hours service they are more likely to use it again (Rajpar et al 2000) as previous experience of a service has a major influence on future choice of service (Philips et al 2010).

McKinley et al (2002) developed a reliable and validated questionnaire to give an important measure of satisfaction. However, as van Uden et al (2005) pointed out, assessing satisfaction through quantitative research methods such as questionnaire

surveys results in a notoriously high satisfaction rate and provides only a limited understanding of the ways that users evaluate their care. Wensing and Elwyn (2003) recognised that individuals are more critical if interviewed in greater depth about processes of care as interviews give participants far greater scope to express different preferences when compared to questionnaires. Glick (2009) stressed the value of interviewing to reduce the risk of 'courtesy bias' in which parents provide misleadingly favourable responses in surveys for fear of being prejudiced against in their future care. Exploring patient experiences through qualitative methods therefore may give a greater insight into the true level of satisfaction than the completion of a questionnaire. Moreover, Thompson et al (2004) argued that the evaluation of out-of-hours care through satisfaction surveys has focused on the process of care (such as telephone triage compared to face-to-face contact) rather than experience. Yet as Philips et al (2010) recognised, experience plays a crucial part in the way that users evaluate the care they have received. The disparity between respondents' answers to a questionnaire and those provided in an interview, suggests that individuals view the concept of satisfaction differently if asked in a questionnaire rather than allowed to express their views and interpretation of events in their own words in an interview.

2.4.6 Summary of help-seeking behaviour literature

The literature surrounding help-seeking behaviour and decision-making gives a clear picture of the complexity of the factors that mothers consider before they decide to seek professional help when their child is unwell during the out-of-hours period. A mother's own beliefs and attitudes towards health (whether making decisions alone or not), how she perceives her child's illness, and how easy it is for her to access health services all have an impact on the decisions that she makes. Parents view access to health services in terms of who they want to see (e.g. nurse or doctor), where they want to see them (e.g. ED, out-of-hours clinic, in a clinic or at home) and how (e.g. face-to-face or via telephone).

Rural communities weigh up the ease of access and the benefit of treatment to a far greater extent than individuals who live in urban communities (Farmer et al 2006; Campbell et al 2006). This provides an insight into the decision-making process of Army mothers within the rural geographical boundary of this study.

The use of the paternalistic decision-making model (in which the clinician makes the decisions about treatment) dominated the literature, not the shared decision-making model (in which parents share responsibility for all of the decisions made). As Kai (1996a) recognised, paternalistic decision-making may have met the parents'

wish to transfer responsibility to a health professional and to be advised how to treat their child.

Most studies emphasized the importance of a mother's role in the assessment of her child's health and identified that it was the mother, not the father, who decided whether to access health professionals. However, much of the literature used the term 'patients' when in fact the researchers were referring to 'parents'. In many studies the terms, 'parent' and 'patient' were interchangeable generic terms for an individual accessing health services regardless of whether the participants were accessing care for themselves as a patient or on behalf of their child as a parent. Also, studies that were more specific and used the term 'parent' inferred that they were referring to mothers rather than both parents, implying that mothers are seen as the principal carer for their children.

Surprisingly, only Kai (1996a; 1996b) acknowledged the possible effect of health scares or major media health campaigns occurring at the time of his study. Walsh et al (2008) stressed also that publicity campaigns do influence parents' knowledge, beliefs, practices, and help-seeking behaviour. Therefore, potentially, they can influence the findings of a study.

Increasingly Health Service researchers have understood the importance of using mixed methods as a strategy for their research. They have used quantitative methodology to ensure that their research could be generalised followed by qualitative methods to increase the depth of enquiry (O'Cathain et al 2007). However, the majority of papers in this review used either quantitative or qualitative methods rather than a mixed-methods approach.

It is not clear why there is such a variation of response rates in the quantitative studies, which ranged from 94 per cent in Gerard et al's (2008) study to 21.5 per cent in Edwards et al's (2009) work as most papers have not given information about their recruitment strategy in sufficient detail. However, most studies have acknowledged that a reduced response rate might reduce the ability to generalise their results.

The majority of literature reviewed originated in the UK. However , some studies were included from the Netherlands (such as van Uden et al 2005; Moll van Charante et al 2006; Giesen et al 2007a; Giesen et al 2007b; Moll van Charante et al 2008; Hugenholtz et al 2009) and Belgium (Philips et al 2010). Reviewing literature from the Netherlands and Belgium has enabled a broader insight into the issues

pertaining to mothers' decision-making when their children are unwell than if only British literature had been retrieved as these countries use a similar out-of-hours health care system to the UK.

2.5 Conclusion of literature review

The military literature regarding Army life paints a picture of the distinctive culture in which Army parents live and suggests that understanding this culture is key to identifying the impact that Army life has on the decisions that mothers make when their children are unwell.

Silverman (2010) stressed the importance of using qualitative research to undertake in-depth enquiry in order to capture experience. It appears that researchers within the civilian community appreciated the importance of using qualitative research as a method of enquiry earlier than military researchers did. This review includes qualitative studies of help-seeking behaviour from as early as 1993 from the USA (Cornford et al 1993) and 1996 from the UK (Hopton et al 1996; Kai 1996b). These two qualitative studies in the civilian literature precede the earliest qualitative study in British military literature (Giles 2005) by 11 years and the earliest US military qualitative study (Huebner et al's 2007) study by 13 years. This demonstrates an earlier appreciation of the benefits of using a qualitative approach in the civilian literature. However, the qualitative studies reviewed in Section 2.3 (such as Dandeker et al 2006; Huebner et al 2007 and Clifton 2007) reflect the fact that the use of qualitative research methods within the UK and the US military literature is increasing. This indicates an increased recognition of the need to explore as well as quantify the impact of Army life in the present challenging operational climate.

Research regarding help-seeking behaviour and the decision-making of parents has taken place in civilian communities who may face different daily pressures to Army mothers. Very little research has investigated the impact that the disruption common to Army life (such as frequent mobility and military enforced separation) has on the decisions that Army mothers make when their children are unwell. The support that Army mothers expect to receive from the out-of-hours service when their child is unwell has not received much attention either.

The lack of research from the deployed mother's viewpoint is surprising as since the Gulf War in 1991 it has become commonplace for women to deploy in a combat role. At present, around 1500 of the present 8,000 British troops serving in Afghanistan are female, many of whom are mothers (Defence Analytical Services and Advice 2011). Also, there is a great diversity in the type of family represented within the Army now. These include single parent families, dual career families,

reconstituted relationships with step parents or children and an increasing number of Army families in which both parents are serving (Booth et al 2007).

There was little evidence in either the military or the civilian literature of the impact that being alone had on the health decisions that mothers made. There was no evidence regarding how early in the decision-making process mothers called out-of-hours services when their children were unwell, for example, whether as a first option or as a last resort once all other options had been exhausted. Studies regarding decision-making have used the assessment of symptoms by the GP as the criteria for appropriateness (such as Shipman and Dale 1999); following on from Giles's (2005) study, further investigation is required regarding the impact of the mother's anxiety level or psychological state on the decision to consult.

'Coping' is a term used frequently within the military literature to describe the strategies used by Army mothers to deal with the pressures of Army life, although the meaning of 'coping' in this context is not identified in the literature. Evidence confirms that times of deployment are challenging for mothers left at home during military enforced separation, particularly deployment. However, the extent to which fear and isolation increase their need for reassurance when their children are unwell is not clear and warrants further investigation.

The insight gained from the literature regarding the features of Army life, help-seeking behaviour and the decision to consult has justified setting the dates of the selection criteria to permit retrieval of literature from over 30 years ago. Many of the older papers (such as LaGrone 1978, Kai 1996a and Shipman and Dale 1999) generated an essential insight into either the impact of Army life or parental decision-making when a child is unwell during the out-of-hours period that would have not been possible had the selection criteria only permitted retrieval of the literature published more recently.

Any military studies from the USA are reviewed with some caution, as different features within the US Armed Forces may reduce the transferability of the findings to a British Army context. For example, Davis et al (2011) acknowledged that deployments within the US Army last 12 to 15 months and occur every 18 to 24 months. Unfortunately, the frequency and length of deployment was not mentioned in the reviewed British literature. However, from personal military experience and newspaper reports by Rayment (2009; 2010), deployments by the British Army tend to have an average duration of six months, although they may reoccur within three months of the previous tour of deployment. In general, deployments within the US

Army are longer but less frequent than deployments within the British Army. Deployment within the US Army may have a different impact on the mother left at home than the shorter but more frequent deployments that occur within the British Army.

There was an apparent lack of clarity and consistency in some military papers of the terms used and how the researchers interpreted their meaning. This may have been due to an assumption that those reading the military literature would have an understanding of military life and a level of tacit knowledge. For example, the US military literature used the less explicit term 'military' rather than specifying to which or all Services it was referring (such as Army, Navy, Air Force or Marines). Yet, the US Army, US Navy, US Air Force and US Marine Corps are known to be culturally very different (Department of Defense 2011). This is unfortunate as each arm of the Services may have fundamental differences that may alter how its features affect its families. The British military literature clarified this better by using the term 'Army' to specify that the research has been undertaken with Army families, or the term 'Service' or 'military' if the research was not specific to a particular arm of the Services. For example, Giles 2005 and Clifton 2007) talked of the 'Army' only. Even though Dandeker et al (2006, p 381) used the term "*Service wives*", they made it clear that the participants in their study were from the Army (rather than from the Royal Navy or the Royal Air Force).

It was important to include all 13 of the military studies reviewed for the insight that they have given of the features of Army life. However, the methodological rigour with which the military studies were undertaken was variable and was a challenge to assess. While some military papers lacked some methodological details to enable the rigour of the study to be established (such as the difficulty in establishing how LaGrone (1978) determined the classification of problems identified from his case review), the military papers gave an essential insight into the impact of Army life. Overall, the military literature was undertaken with less methodological rigour than the civilian literature, but had to be retrieved from a much smaller pool of research. This created a dilemma whether the military literature had been completed with a sufficient level of methodological rigour to warrant inclusion in this review. The exclusion of the limited military literature available would have been detrimental to this study. Reviewing these papers enabled me to gain a greater understanding of what the features of Army life were, and so determine what features and their impact required greater exploration for the fieldwork. For example, had I not included Davis et al's (2011) paper because of their use of convenience sampling, I would have excluded some important

evidence that deployment had a substantial emotional impact on the family left at home. I had no such dilemma reviewing the methodological rigour of the civilian literature because of the far greater volume of methodologically sound literature available. The difference in volume is demonstrated by the number of papers that met the inclusion criteria reviewed for each section of this chapter. Section 2.3 reviewed 12 military papers from both the UK and the US to explore the features of Army life. This was all the papers that could be retrieved that met the inclusion criteria. In contrast, I identified 101 civilian papers to review for Section 2.4 regarding help seeking behaviour; these were the most relevant evidence of literature undertaken with methodological rigour from a far larger pool of research.

Most military literature did not comply with the traditional format for publications in civilian literature (for example, introduction, aim, method, results or findings, interpretation and discussion). This may have accounted for why significant methodological details were excluded in some studies which made the strength and weaknesses of the military papers more difficult to determine, for example, both Vincenti (1990) and Blount et al (1992) omitted details of their inclusion criteria for their literature reviews.   Civilian studies gave more detail about their study design (such as the sampling frame) which enabled their methodological rigour to be more fully assessed.

It is clear from the military studies that gave details of the recruitment procedure (Fernandez-Pol 1988; Ryan-Wenger 2002; Giles 2005; Dandeker et al 2006; Huebner et al 2007 and Davis et al 2011) that the recruitment of Army families into military studies can be difficult. Dandeker et al's (2006) high response rate of 89% demonstrated the benefits of using military contacts to aid recruitment, such as Unit Welfare Officers from outside the research team. Despite using a variety of strategies to improve recruitment, the quantitative phase of Ryan-Wenger's study (2002) study was of insufficient power to detect a real statistical difference across the groups. Had a pilot study been undertaken (as Dandeker et al (2006) had done), Ryan-Wenger (2002) would have been aware that while children were keen to participate, the reluctance of their parents to consent to their participation would make it difficult to recruit a large enough sample to be representative. However, Ryan-Wenger (2002) illustrated useful ways to increase awareness of the study by publicising it as widely as possible within the Regiment from which it is hoped to recruit.

Grbich (2007) points out that convenience and snowball methods of sampling are known to be the least robust method of sampling in terms of conceptual

trustworthiness for a qualitative study. The quality of the sampling method varied in the military studies. However, despite Davis et al's (2011) use of this method of sampling, Davis et al (2011, p 55) identification of the "*roller coaster of contradictory emotions*" was an important finding, and so warranted inclusion of their paper in this review. Davis et al's (2011) work endorsed Giles's (2005) finding earlier, that deployment had a significant emotional impact on the family left at home. Other qualitative studies (Giles 2005, Dandeker et al 2006 and Clifton 2007 from the UK and Huebner et al 2007 from the US) acknowledged the importance of using purposive sampling to identify key informants. The quantitative studies (Dandeker et al 2006 from the UK and LaGrone 1978; Morrison 1981; Fernandez-Pol 1988, Ryan-Wenger 2002 from the US) demonstrated an understanding of the importance of randomisation to identify a representative sample in quantitative studies. However, both LaGrone (1978) and Morrison (1981) chose to review all of the retrospective data that has been collected in the previous two years and six years respectively, rather than taking a representative sample.

Engaging in reflexivity and acknowledging the relationship of the researcher with participants is important in qualitative research (Holloway and Wheeler 2010). Clifton (2007) used field notes as a reflexive tool. Giles (2005) acknowledged that her position as a nurse practitioner in the practice in which the study took place may have influenced the study but did not expand further. Yet, Dandeker et al (2006) and Huebner et al (2007) did not identify whether their own position and viewpoint might have influenced the study. As in this study, the principal investigator in Davis et al's (2011) study researched the population of which she was a part. Even though Davis et al (2011) recognised the importance of reflexivity, rather than keep a reflective diary, they chose an unconventional research design in which one of the co-researchers interviewed the principal investigator to identify her previous experience, assumptions and viewpoint. Only Dandeker et al (2006) and Clifton et al (2007) confirmed that their study had received ethical approval.

Research within the civilian literature concentrated on specific aspects of out-of-hours care, which enabled the research to be focused. For example, Turnbull et al (2008) explored the impact of geographical location in depth because they chose to focus on a specific aspect of the use of out-of-hours services rather than the multiple factors that affect access to out-of-hours care. In contrast, Blount et al (1992) explored the all-encompassing issue of "*family separations in the military*".

The lack of data reported in some military papers made it difficult to determine whether the researchers' conclusions came directly from the data or whether they

were influenced by their personal experience. This reduced confidence in their interpretation of their findings. Many of the authors of military papers were clinicians, including psychiatrists (LaGrone (1978), Morrison (1981), Fernandez-Pol (1988), Vincenti (1990) and a therapist (David et al 2011). These researchers would therefore have had clinical experience of more extreme psychopathology that may have influenced their studies. However, this did not seem to affect the quality of the civilian literature, in which many of the researchers were clinicians also (such as Kai 1996a, 1996b, Shipman et al 1997a, 1997b, 2000, 2001).

It is not possible to identify from the military literature how the distinguishing features of Army life (such as military enforced separation and frequent mobility) influenced the decisions that Army mothers make, only Giles (2005) acknowledged it may increase the mother's emotional vulnerability. There was so little evidence in either the military or the civilian literature that explored the impact that being a lone parent has on the decisions that mothers make, that it is not possible to conclude how this influences the decisions that mothers make when their child is unwell.

An astonishingly little methodologically robust military research has been undertaken to explore how disruption, military enforced separation, and the realities of Army life affect British Army parents, particularly when making decisions alone when their child is unwell. The terms 'transience' and 'disruption' were used to explain the 'disruption' of frequent mobility and the 'turbulence' that it created, yet these terms were not defined clearly in any military paper. This was in direct contrast with the civilian literature that did not assume such knowledge. For example, O'Cathain et al (2008, p 19) gave a clear definition and many examples of what they meant by the term "*urgent care*".

Healy and McKee (2004) acknowledged in their book "*Accessing Health Care Responding to Diversity*" that policy makers have a responsibility to be responsive to the diverse needs of the population of their country. The Department of Health (2010b) has encouraged commissioners and providers of health care to seek and respond to the views of patients. The Army Medical Services (AMS) has a responsibility to ensure that health provision for Army parents is appropriate and accessible as part of its role in fulfilling the Military Covenant (Ministry of Defence 2008a, p 8). Further military research is required which explores the reality of living as a parent within an Army environment.

The literature has explored that disruption can take many forms. The impact of disruption, frequent mobility and military enforced separation needs to be investigated further to identify how these features affect the decisions that mothers make when their child is unwell during the out-of-hours period. However, as most studies included non-serving wives as their participants, it is not evident from the literature whether serving status has an impact on the decisions that parents made, whether it is common for Army fathers to be the primary carers of their children or whether Army duties prevent mothers from being at home to look after their children. Participants are referred to as 'wives' within the military literature, this indicates that identity as an Army wife is important. However, whether ensuring a sense of identity as an Army wife is part of an Army mother's coping strategy is not clear and warrants further exploration as well as whether being part of a Corps or a Regiment has an impact.

In the past, health care was provided by the Army health professionals who understood the Army culture in which these parents were living. In the present political climate Army families integrate fully with their local community and access NHS health care, the providers of which may not be aware that they are an Army family at all. Expanding the knowledge base should enable the health needs of Army mothers to be met more effectively when their child is unwell at a time when they are at their most emotionally vulnerable.

The literature has fallen into two distinct overarching categories. Section 2.3 has reviewed the military literature that is related to Army culture and impact that Army life has on Army families. Section 2.4 has reviewed the literature related to decision-making, help seeking and out-of-hours health care provision to the civilian population. Only Leach et al (1993) and Giles (2005) have undertaken empirical research that links both sections.

It was not possible to conclude from the literature whether types of military enforced separation (i.e. deployment and training exercises) affect Army mothers in different or similar ways or how being a lone parent impacts on the decisions a mother makes when her child is unwell. The literature lacked clarity and detail as to whether the impact of Army life causes Army mothers to require additional or different support to their civilian counterparts. Also, there was little evidence regarding how a mother's emotional state impacts on her decision-making and the coping strategies that are used by Army mothers, or whether being part of a Corps or a Regiment affects an Army mother's sense of belonging, identity and sense of isolation. Overall the evidence within the civilian literature was undertaken with a

greater degree of methodological rigour than the military literature. However, it was essential to include military studies reviewed in this chapter because of the vital insight they provided regarding the impact of Army life. Also, it was essential to establish the knowledge base that existed prior to this study ensure that this study built on existing knowledge as well as to guide the formulation of the research questions and methodological design for the study by considering different research strategies used by others.

In conclusion, a review of the military and civilian literature has identified that limited knowledge exists regarding how and in what ways disruption, mobility and enforced separation affect parents living with young children within a garrison in England. It was apparent that investigating the impact that Army life has on mothers' decision-making within the confines of a PhD thesis would make a vital contribution to understand the psychological, emotional and logistical support Army parents required.

This study adds to the existing evidence by describing the experiences of Army parents living and working within an Army garrison and Army life means in reality. In order to do so, it captures the unpredictability of Army life, the impact of military enforced separation, the fear deployment generates and the disruption caused by frequent mobility and a difficulty to plan. It identifies the coping strategies employed by Army parents to combat the challenges that the Army presents them with. It gives insight into how the decisions that Army mothers make when their children are unwell during the out-of-hours period are influenced by their ability to cope as a lone parent during a time of stress and anxiety. Therefore, this study builds on existing knowledge of a lone civilian parent's decision-making by its exploration of the experience and reality of living as an Army parent within in a garrison during a period of intense military activity.

2.6 Summary of chapter

This chapter has discussed the evidence regarding the features of Army life, help-seeking behaviour and decision-making during the out-of-hours period and the theoretical concepts related to my research questions. The main themes that emerged from the military literature were the impact of daily disruption, frequent mobility and military enforced separation on the lives of Army families. The civilian literature relating to help-seeking behaviour and decision-making has been discussed in connection to the lone parent, parents' own beliefs and attitude to health, mothers' assessment of the child who is unwell, accessibility of services and users' satisfaction. A review of this literature has highlighted the complexities of parental decision-making and has identified the key issues that demand exploration

within a military context with Army parents. It has highlighted also the importance of maintaining reflexivity. It was essential for me to ensure that neither my tacit knowledge nor my military experiences were influencing me to make assumptions from the military literature that a civilian who had less knowledge of the Army would be able to do.

The next chapter (Chapter 3) discusses the study design, strategy of inquiry, methods and process of analysis employed for the study.

Chapter 3 Study design, methods and analysis

3.1 Introduction

The previous chapter indicated that whilst parental decision-making is a complex process and Army life has a major impact on the lives of Army parents in so many respects, there appears to be very limited empirical evidence regarding the impact that Army life has on the decision-making of Army parents when their children are unwell. This chapter describes the strategy of inquiry employed to investigate the phenomenon of decision-making in these circumstances.

Researchers are guided by a set of beliefs from which they form a framework to help them understand and interpret the world in which they are studying (Denzin and Lincoln 2005). These beliefs are presented within this chapter, which explores how my beliefs have influenced the research strategy, the sampling approach and the chosen methods of data collection. My role as an insider within the organisation of study (the Army) has clearly influenced the choice of research focus and the interpretation of the findings, the implications of which will be explored also.

3.2 Overarching approach to the research

Denzin and Lincoln (2008) ascertained that the constructivist paradigm assumes a relativist ontology (that there are multiple realties) and a subjectivist epistemology (that the researcher and participants co-create understanding) within a natural setting. Furthermore, according to Lincoln and Guba (1985, p 39) *"realities are wholes that cannot be understood in isolation from their contexts"*. Stake (1995) argued that reality is a mixture of interpretation and rationalisation of experience, and so the researcher's experience plays a major part in how knowledge develops during a study. Also, as Creswell (2007) suggested, social constructivist researchers seek to understand the world in which their participants live in order to enable them to interpret their cultural and social context. Thus, a constructivist viewpoint lends itself to an in-depth qualitative study of a social setting and the exploration of a phenomenon within that setting, taking into account the context and culture of the setting.

The aim of this research was to identify the impact that Army life has on the decisions that mothers make when their child is unwell during the out-

of-hours period. In order to achieve this aim, the study design was developed to answer the following research questions:

1.   How (and in what way) do the features of Army life affect the daily lives of Army parents?

2.   How do aspects of Army life influence the decision-making of mothers when their child is unwell during the out-of-hours period?

3.   What support do Army mothers expect during the out-of-hours period when their child is unwell?

It was evident using a case study design would be appropriate, given that the philosophical beliefs of constructivism were underpinning the research, its aims and research questions. This supported Stake's (1995, 2000, 2008) interpretation of case study rather than Yin's (2009) more positivistic approach. However, both theorists give valuable details of the issues that must be considered when designing a constructivist inquiry using a case study approach.

3.2.1 Case study

Case study design is viewed in a variety of ways. For example, Creswell (2007) considered a case study to be a methodology, whereas Yin (2009) referred to it as a research strategy. On the other hand, Stake (2008, p 121) regarded it not as a methodology but as a "*choice of what is to be studied - a process of inquiry about the case and the product of that inquiry*".

Appleton (2002) suggested that many definitions of case study exist and offered her own:

> *An intensive analysis in which the inquirer attempts to examine and understand key variables which are important in determining the dynamics of a situation in order to provide detailed insight into a specific phenomena of interest.*
>   (Appleton 2002, p 82)

Appleton's (2002) definition lends itself to this study as it highlights the importance of understanding the key issues that impact on the phenomenon of interest. The literature reviewed in the previous chapter has already confirmed that Army life has a major impact on the day-to-day

experiences of Army parents; therefore, this has to be taken into consideration in order for a mother's decision-making processes to be explored effectively.

Creswell's (2007, p 73) definition of case study is helpful also, as it emphasizes the importance of in-depth data collection and acknowledges the flexibility of using case study as it can consist of one or more cases and its boundaries can be interpreted in alternative ways:

> *The study of an issue explored through one or more cases within a bounded system (i.e. setting or context)... through detailed, in-depth data collection involving multiple sources of information (e.g. observations, interviews).*

(Creswell 2007, p 73)

Stake (1995, p 3) highlighted the challenges of identifying what the "*case*" is, the "*unit of analysis*" and its boundaries. Yin (2009) considered defining the 'case' to be crucial, yet notoriously difficult to do. This is partly because of a variety of views of what comprises a case, from a group or individuals (Stake 1995), to a situation (Bromley 1996) or a process (Ragin 1992). As Patton (2002) acknowledged, it is crucial that the object of study is clearly defined. Appleton (2002) argued that the phenomenon of interest and context of the study constitute the case. She maintained that it is important to identify how the case will inform the fieldwork and thereby increase understanding of the phenomenon. This study aimed at increasing understanding of the impact of Army life on parental decision-making by allowing Army mothers to explore their experiences of both Army life and the decisions that they had made when their children had been unwell.

3.2.2 Rationale for the research design

There was no evidence that any Army studies of this kind had been undertaken, so no precedent for an appropriate study design had been set. Yin (2009) suggested that the whole strategy of the research stems from the research questions as they define the 'substance' (what the study is about) and the 'form' of the question (what type of question is being asked). According to Creswell (2009), the type of research questions determines the best approach of inquiry for a study. Since the research questions began with the words 'what' and 'how', this indicated a research design was required which would facilitate a response to open-ended

research questions, so that a rich description could be developed of what Army life was really like from an Army mother's perspective.

Appleton (2002) confirmed that it is essential that a phenomenon is studied in context for an understanding of the complexities of the 'case' to be achieved. Yin (2009, p 18) advocated that not only must a case study be undertaken within *"its real life context"*, but also without manipulation or intervention. It was important from a constructivist viewpoint to generate knowledge and understanding from the perspective of the participants, rather than start with a theory to be proved or disproved. The phenomenon of Army mothers' decision-making had to be explored with actual mothers who had direct experience of managing a child who was unwell within their *"real life context"*, as it was the mother's viewpoint that was of prime interest. Therefore, an Army garrison in which Army parents lived and worked provided a natural geographical boundary to the 'case' and was the setting in which the study was located.

Stake (2008, pp 121-123) classified three types of case study- *"intrinsic"*, *"instrumental"* and "*multiple or collective"*. This study is regarded as an "*instrumental"* case study as it aimed to prove insight into an issue in which the 'case' played a "*supportive role"* to facilitate understanding of *"something else"* (Stake 2008, p 123). The objective of this study was to capture the *"something else"* - the issues and complexities surrounding the impact of Army life and parental decision-making. As Stake (2008) recommended, the 'case' (Army parents) was used as a vehicle to increase understanding of the phenomenon (the impact of Army life on parental decision-making) rather than studying the 'case' of Army parents *per se.*

As Stake (2008) advocated, a major strength of using a case study approach is that it supports the use of many different sources of evidence to help answer the research questions. During Phase One of this study, fieldwork was conducted using focus groups in order to explore how Army mothers talked about the support that they needed during the out-of-hours period when their child was unwell. The remaining two phases of the case study (Phases Two and Three) used interviews as a method to generate the data. Kvale and Brinkman (2009 p 48) illustrated the different epistemological conceptions of interviewing as *"knowledge collection"* or *"knowledge construction".* Use of *"knowledge construction"* in this study encouraged the participants to tell their own stories in their own words and

supported the exploration of the issues raised in greater depth as themes emerged as the study progressed. A research log was kept throughout the study to capture observations and thoughts, which were used to support the fieldwork and analysis.

It became apparent during Phase One that Army life had a major impact on the lives of Army parents. It was clear also, that mothers were the principal carers for the children during times of deployment and military enforced separation, which had an effect on the associated decision-making process when their children were unwell. It was evident that the themes surrounding the impact of Army life on Army parents, which emerged during Phase One of the study, needed to be explored in greater depth. This was a task undertaken in Phase Two of the study by recruiting a sub-sample of seven parents who had taken part in the focus groups and who subsequently agreed to be interviewed (considered further in Section 3.3.2).

Phase Three of the study involved a new sample of participants because the intention was to target mothers who had actually sought help from a health professional during the out-of-hours period and thus had direct and recent experience of help-seeking when their child was unwell.

Whilst all phases of the study contributed to answering all three of the research questions, Phases One and Two primarily focused on answering the first research question, while Phase Three mainly addressed the second and third research questions. Figure 3.1 depicts the study design, it illustrates the phases of the study, the number of participants, data collection methods and the dates that the fieldwork took place.

Figure 3-1 Design of the study

Phase One	Phase Two	Phase Three
Phase One Impact of Army life on Army parents	**Phase Two** The impact of Army life on Army parents (in depth)	**Phase Three** Mother's decision-making
Focus groups April to May 2008	**Interviews** October to November 2008	**Interviews** February 2010
24 Participants 3 serving mothers 17 non-serving mothers 4 serving fathers	**7 participants** (Sample from Phase One) 2 serving mothers 3 non-serving mothers 2 serving fathers	**7 participants** 1 serving mother 6 non-serving mothers

3.2.3 Boundaries of the case study

Denscombe (2007) acknowledged that setting the boundaries for a case study is crucial to providing it with a distinct identity and ensures that the study remains focused on the phenomenon being studied. Creswell (2009) characterized a boundary for a case study to consist of several components, which include the time, setting or context of 'the case', 'key informants' who provide the information required to answer the research questions, and events and processes. The following are the boundaries for this study:

- Time - The duration of the fieldwork (2008 to 2010).
- Setting - The garrison where the study took place.
- Key informants - Army parents living or working within the garrison.
- Events - The everyday experience of living as an Army parent and the decision-making of Army mothers when their child is unwell during the out-of-hours period.
- Processes - The ethical considerations (discussed in Section 3.8).

3.3 Sampling and case selection

Sampling is the purposeful selection of a section of the whole population to gain knowledge and information (Holloway and Wheeler 2010). Stake (1995) suggested that the aim of sampling is to target individuals who will

increase understanding of the case so that the researcher can maximise their knowledge of the phenomenon. Decisions about which sampling method to choose are influenced by the aims of the study, existing knowledge, gaps in the existing knowledge and in response to findings which emerge during the course of the study.

Ritchie and Lewis (2003) pointed out that a deliberate non-random method of sampling has features or characteristics which enable detailed exploration and understanding of the case to be investigated. Purposive sampling as a non-random method of sampling was chosen for this study to maximise understanding about parents' experience of Army life and how it impacted on a mother's decisions when her child was unwell.

3.3.1 Purposive sampling

Kitzinger (2006) and Creswell (2009) advised the use of purposive sampling as a way to target 'key informants'. In this study, the 'key informants' were Army parents with experience of the impact of Army life, who had an interest in health care provision for their children and felt comfortable to share their views. As has been highlighted in Section 1.4 and Chapter 2, serving mothers and fathers had not been well represented in previous research. Therefore initially, it was important to include a variety of Army parents in my sample. This comprised both serving and non-serving mothers and fathers, who were parents of one or more children.   Sampling aimed to gain as many relevant perspectives as possible to increase my insight into the impact of Army life on a mother's decision-making.

3.3.2 The sample

Decisions are made about the criteria for selection in the early design stages of the research when purposive sampling is used. I considered the following aspects in order to determine the selection criteria for the sample:

The homogeneity of the population: All of the participants were members of an Army family, irrespective of their serving status, which increased the homogeneity of the population.

The heterogeneity of the population: The impact of rank, whether serving or non-serving, the number of children the parent had, and the length of time within the Army population were taken into account. This was to

ensure that the heterogeneity of the population was not too great to prevent the fieldwork to be focused on answering the research questions.

The need to target participants with the most knowledge: I was interested to explore the impact of Army life in relation to a particular phenomenon, and I considered it necessary to gain as wide a perspective as possible of its impact on parents in the initial phase. Consequently, it was important that both serving and non-serving mothers and fathers were included for Phase One. Subsequently it became evident that it was the mothers who were central to increase my understanding and therefore they became the focus of my sample in the second and third phases.

Type of data collection methods used: The first stage relied on focus groups which necessarily called for a larger sample than individual interviews, which was the method of choice for phases two and three.

3.3.3 Inclusion criteria

It was estimated that the original sample needed to be drawn from approximately 1500 Army parents who lived or worked within the garrison. Inclusion criteria were derived for each phase of the study. The overall criteria are shown in in Table 3.1.

Table 3-1 Overall inclusion criteria for the study

Each participant needed to:
- Be an Army parent.
- Remain in the garrison for the following three months, thus available to participate.
- Have had experience of their own child being unwell.
- Be a parent of at least one dependant child registered at garrison's medical centre.
- Live or work within the geographical boundary of the study (the garrison).
- Be serving themselves or partner/ spouse of serving soldier or officer.
- Not to have been notified of the death or very serious injury of their partner/ spouse.
- Be a native English speaker (some parents in the garrison were Fijian).

Ensuring that a participant was not due to leave the garrison within three months of selection reduced the risk of participants not being available between recruitment and the fieldwork taking place. In order for their decision-making to be explored, it was necessary for the participants to have had some experience of their child being unwell, no matter how minor the illness or injury.

Including parents whose child was registered with the garrison's medical centre enabled compliance with the Data Protection Act 1998 (The National Archives 2010) and permitted the nurses who were facilitating recruitment to access the parents' contact details from the child's medical records. Checking for notification of very serious injury or death was important. I did not want to add to a bereaved parent's level of distress by inviting then to take part in the study when their spouse had recently been seriously injured or killed.

I was aware from my own military experience that Army parents whose country of origin was outside United Kingdom, such as the Fijians living within the garrison, originated from a different culture to British Army families. Also, it was possible that cultural background could influence a mother's decision-making when her child was unwell. As a result of this, and because there was no funding for translation, the inclusion criteria included only Army parents whose native tongue was English. In the event, no Army parent who originated from a country outside the UK expressed an interest in taking part in the study.

As discussed in Section 2.3.1, many military studies (such as LaGrone 1978 Morrison 1981, Fernandez-Pol 1988, Giles 2005), had sampled mothers who suffered from mental health problems. I, on the other hand, wished to exclude parents who had a history of psychiatric illness, as I felt this may raise issues that were not the focus of my study. Unit Welfare Officers who were assisting with the recruitment did not have the authority to access patients' medical records, but knew most of the participants personally. Therefore they did not invite any parent to take part if there was any indication that the parent had previously been treating or was undergoing medical treatment for mental health problems.

Sampling criteria for Phase One
It was important for the initial phase of the study (Phase One) to include both fathers, as well as serving and non-serving mothers. This was because prior to this study there was insufficient evidence about what the distinguishing features of Army life were and how they impacted on the decision-making of Army mothers when their children were unwell. I hoped that using purposive sampling would facilitate a variety of responses from participants so that I could identify themes as well as contradictory evidence that could be developed in greater depth in Phase Two of the

study. Homogeneity capitalises on the participants' shared views and experiences and helps to generate meaningful discussion (Kitzinger 2006). The sample was homogenous in that the participants who were selected had the commonality of being parents who had experience of Army life within the same garrison. Also, they were passionate to promote the health needs of their children (see Table 3.1 for inclusion criteria and Appendix 2.2 for participant details).

Sampling criteria for Phase Two

Giles (2005, p 215) acknowledged that the Army mothers that took part in her study seemed inhibited by the interviewer's presence, sometimes giving what appeared *"appropriate"* answers. As a result, she recommended that "*richer*" data would have been obtained by re-interviewing the same participants with questions developed from the preliminary data. Participants attending the focus groups during Phase One expressed an interest in taking part in further stages of the study and this enabled me in the second phase to explore issues, both new and previously mentioned, in greater depth than in the focus groups. In addition, I had built a rapport and trust with the participants during Phase One and considered that this would remove some of the barriers that may have inhibited new participants from contributing freely (see Appendix 2.3 for participant details).

Table 3.2 demonstrates the criteria that were applied to this phase of the study in addition to that specified in Table 3.1.

Table 3-2 Inclusion criteria for Phase Two

Inclusion criteria
Each participant needed to: Fulfil the inclusion criteria of Phase One. Be a parent who had participated in Phase One of the study.

Sampling criteria for Phase Three

It was considered that data saturation had occurred with parents engaged in the first two phases and thus a new sample was targeted. A new sample was recruited for Phase Three of mothers only, as it was clear from the data that was emerging from the study (and confirmed by evidence from the literature, such as Richards et al 2007), that mothers were the principal carers of their children. Also, it was mothers who made the decisions about whether to access health services when their children were unwell,

this was regardless of their serving status. Military enforced separation appeared to have a profound impact on Army mothers, both psychologically and in practical terms. Therefore, Phase Three focused on exploring the decision-making of Army mothers who had accessed health services when their child had been unwell during the out-of-hours period and their husband was absent due to a period of military enforced separation. Table 3.3 illustrates the additional criteria that were applied to this phase.

Table 3-3 Inclusion criteria for Phase Three

Inclusion criteria
Each participant needed to: • Fulfil the inclusion criteria of Phase One. • Not have participated in previous stages of the study. • Be mother of a child under ten years old. • Have had a child who had been unwell with a common childhood illness or injury (e.g. fever, rashes, coughing, wheezing, breathlessness, diarrhoea and vomiting, minor injury or infection) within the previous month of being recruited. • Have accessed a health professional during the out-of-hours period for their child within the previous month. • Have consulted during a period of military enforced separation.

A timeframe of one month was chosen to minimise the time lag between the service contact and the interviews taking place. This allowed sufficient time for the episode that prompted the call to have been resolved or treated, without too much loss of memory of the details of the decision-making process. Including children who had presented with common symptoms only increased the chances that the illness or injury had been treated effectively, so that the mother did not have the additional anxiety of the child remaining unwell at the time of the interview. In addition, checking for notification of very serious injury or death was particularly important during Phase Three of the study when an ever increasing number of soldiers from the garrison were being seriously or fatally wounded in Afghanistan (see Appendix 2.4 for participant details).

3.3.4 Sampling frame and size

Once the garrison of 1500 Army families had been selected as the study population, it was necessary to determine a sampling frame from which a sufficient number of participants could be selected.

As Richie and Lewis (2003) highlighted, sample size is an important consideration in qualitative research. The sample needed to be small enough to enable each unit of data collection to be analysed in sufficient

depth for the 'richness' of the data to be exploited, but large enough to answer the research questions.

I was conscious not to recruit too many participants as ethically participants should not be interviewed once theoretical saturation has been reached, which, as Glaser and Strauss (1967) stated, is when new concepts consistently replicate earlier ones. Further data would not contribute to new evidence by this stage.

Phase One

The sampling frame consisted of approximately 200 serving and non-serving parents within the garrison whose children attended parent and toddler groups, nurseries, primary schools and Regimental coffee mornings within the garrison during the period of recruitment (January to March 2008) and who met the inclusion criteria in Table 3.1 (see Appendix 2.2). The serving parents who volunteered to participate held a rank which ranged from junior soldier (corporal) to middle ranking officer (major).

Prior to the study, it was not known how many focus groups or number of participants would be required to explore the participants' knowledge and experience of the issues regarding the features of impact of Army life. Reviewing both military and civilian studies indicated that undertaking four exploratory focus group discussions with up to 40 participants should be sufficient to generate meaningful exploratory data. I obtained ethical clearance to undertake further focus groups had the data analysis suggested that this was necessary.

The number of participants estimated to make four focus groups viable was determined by reviewing the response rates in previous military and civilian qualitative studies. For example, Ryan-Wenger's study (2002) demonstrated that the increased mobility of military personnel could result in a low response rate and a high attrition rate, while Farmer et al's (2006) study had a 30% response rate. I concluded from these that the targeted sample needed to be at least four times larger than the approximate 40 participants required for the focus groups, so approximately 160 participants.

Phase Two

The sampling frame for the second phase consisted of the 24 participants who had taken part in Phase One, all of whom were invited to take part in Phase Two (see Appendix 2.3).

Phase Three

The sampling frame for Phase Three consisted of a new sample of mothers of children whom had accessed the out-of-hours clinic when their child had been unwell in the previous month (see Appendix 2.4). On average, 20 parents were accessing the out-of-hours clinic per month at the time of the research. Therefore, recruitment of ten participants was predicted to take two months, assuming an approximate 25% response rate. In fact, at the time of recruitment (January 2010), 28 mothers had accessed the out-of-hours clinic in the previous month and the first ten who fulfilled the selection criteria were invited and all agreed to potentially participate. This made recruitment much quicker than anticipated.

3.4 Recruitment

Participants were recruited using a different procedure for each phase, which is discussed in Section 3.4.2 (Phase One), Section 3.4.3 (Phase Two) and Section 3.4.3 (Phase Three). However, in order to recruit to the study, it was necessary to increase awareness of the study within the garrison to encourage participation.

3.4.1 Raising the profile of the study

Ryan-Wenger (2002) and Davis et al (2011) suggested innovative ways to enhance recruitment and increase awareness of the study by advertising it as widely as possible. Wide publicity proved an effective strategy for this study. I assisted the Unit Welfare Officers to disseminate leaflets throughout the garrison and to target locations around the garrison that Army parents attended with their children, such as parent and toddler groups, primary schools, day-care facilities and Regimental coffee mornings. The Army nurses publicised the study in the garrison's medical centre. Publications in Regimental newsletters, displays on military notice boards and presentations at Unit welfare meetings by the Unit Welfare Officers were all effective methods of raising the profile of the study within the garrison.

I spent three months familiarising myself with the study setting to become acquainted with the 'case' and its context as Stake (2008) recommended, as this is in keeping with constructivism and case study design. Stake (1995) emphasized the importance of taking the time to become acquainted with the people and the environment of the case prior to data gathering. I attended garrison welfare meetings and long established Unit coffee mornings to meet as many Army parents as possible before

recruitment began. Also, I witnessed Army parents undertaking their daily activities and made field notes in my research log of my thoughts and observations. Even though I was serving in the Army myself and had lived and worked within the same garrison, I had never attended a Regimental coffee morning, taken part in Regimental life, or visited areas where non-serving Army wives socialised during the day. I had no experience of Regimental life, except as a child, as I am serving with a Corps.

Giles (2005) and Dandeker et al (2006) used military contacts such as Unit Welfare Officers from outside the research team to act as facilitators to increase their response rates and enable them to gain access to the participants. Dandeker et al (2006) acknowledged that capitalising upon the Unit Welfare Officers' knowledge of the families within their Regiments contributed to the high response rate within their study. The Army nurses from the garrison's medical centre and the Unit Welfare Officers became key facilitators to enable me to gain access to the participants for this study, as they knew many of the parents personally and so could target parents who were likely to be 'key informants'. As Holloway and Wheeler (2010) pointed out, such individuals have the power to grant or deny access to the research setting, so it was essential to gain their support. The publicity that the Army nurses and the Unit Welfare Officers gave the study proved invaluable. It encouraged parents who had an interest in the subject matter of the study and felt comfortable to share their views to come forward, which increased the recruitment of enthusiastic and well informed participants. I explained the purpose of the study to them and discussed the risk of selection bias prior to recruitment. I was aware that the Army nurses and Unit Welfare Officers may have had a vested interest in promoting particular individuals to take part in the study and target individuals to take part who endorsed their own views. The data analysis demonstrated that there was a variety of evidence and indicated that biased selection had not occurred.

3.4.2 Recruitment for Phase One

Recruitment for Phase One to obtain a targeted sample of 160 (see 3.3.4 above) took the longest as it included the time required to raise the profile of the study. Initially the Army nurses from the garrison's medical centre sent parents a letter via the postal system to invite parents to take part. They identified parents from the list of patients registered with the garrison's medical centre who met the inclusion criteria. The response was negligible however, and thus necessitated a change to the recruitment procedure from using the post to direct contact via the telephone

or face-to-face. The nurses and the Unit Welfare Officers knew many parents because of their professional role within the garrison. The nurses had met numerous parents who had attended the garrison's medical centre when their children had been unwell. The Unit Welfare Officers knew soldiers serving with their Regiment or Corps and their families. This enabled the nurses and the Unit Welfare Officers to identify parents to invite to take part in the study who not only met the inclusion criteria, but also whom they thought would be good informants because of their experience of Army life as a parent. For example, they knew which parents had spent many years as part of an Army family, during which time they had experienced frequent mobility and military enforced separation, but who were also thought to be interested in contributing to the study. This recruitment strategy proved to be much more successful. As a result, the Army nurses and the Unit Welfare Officers continued to recruit participants via the telephone or face-to-face to invite them to take part for the remainder of the study.

I was aware of difficulties of recruiting to military studies because of the frequent mobility of military families identified in the literature, and from my own experience. Therefore, even though the target of 40 participants for the focus groups had not been reached, after three months I decided to curtail recruitment and commence the fieldwork. I was concerned that the participants who had been recruited at the beginning of the three month recruitment period might relocate and so need to withdraw from the study. As 35 out of the 160 invited agreed to take part, this translated into a response rate of just under a quarter. Of these 35, a number were not subsequently available for the focus groups because of work or family commitments and I ended up with 24 participants for the focus groups (see Appendix 2.2).

3.4.3 Recruitment for Phase Two

I agreed to present the participants from Phase One with a summary of my findings from the focus groups, as Holloway and Wheeler (2010) advocated. In doing so, I sent each participant a letter, enclosing ten summary statements, inviting them to challenge my ideas and interpretations and to state if they wished to participate further in the study, as many had previously indicated that they wished to do so. I also included a reply slip and my contact details (Appendix 8.4). This put the onus on each participant to contact me if they wish to contribute to the study further and so avoided coercion.

Of the 24 participants from Phase One, seven agreed to be interviewed. There was no characteristic feature which could explain why the remaining 17 declined to take part, but many of the participants in the focus groups were the spouses of soldiers who were preparing for deployment, which may have made attendance at an interview difficult.

3.4.4 Recruitment for Phase Three

I received ethical clearance to allow the Army nurses to contact up to 30 mothers who had not previously been invited to take part in the study and who had accessed the out-of-hours service within the previous month. The Army nurses contacted each prospective participant as part of a follow-up call resulting from their visit to the out-of-hours clinic. Once the nurses had completed their follow-up questioning, they reminded mothers that this study was taking place. In fact, many parents were aware of it, as the study had been advertised widely within the garrison by this time. The nurses asked them if they would consent to being sent an invitation letter to the study. The nurses reported to me that they had received a very positive response from each mother they contacted. Mothers had apparently expressed their delight that their viewpoint was being considered in a research study and they indicated that they were very keen to talk to me about their recent experience when their child had been unwell.

The names of those military Units and soldiers deployed at the time were public knowledge within the garrison. Since the children's medical records included the name of the serving parent's Unit, the Army nurses were thus in a strong position to identify which mother was a lone parent at the time of the child's consultation. The Army nurses used two methods to retrieve the names of children whose fathers were deployed and who had been unwell within the previous month. This depended on whether the mother had accessed the NHS out-of-hours clinic or the emergency clinic held in the garrison's medical centre between 1630 and 1830 hours each day. For the first method, they looked at the children's medical records that had been faxed from the out-of-hours clinic the morning after the child's consultation; for the second method, they consulted the list of the children's names who had attended the emergency clinic.
 I asked the Army nurses to facilitate recruitment of ten mothers initially. I did not want to disappoint mothers who wished to share their experiences if I could not interview them once no new themes were emerging. Mothers were contacted in order of how recently they had accessed out-of-hours

services, with the mothers who had consulted it the most recently being telephoned first. All ten mothers who were invited to take part agreed to do so. When it came to the interviews taking place, however, three potential participants were not available because of family commitments, leaving seven mothers to be interviewed. Further recruitment was considered a possibility.   Nevertheless, it seemed that after the seven interviews, no new data were apparent and it was concluded that theoretical saturation had been reached and additional fieldwork was not necessary.

3.4.5 The paperwork

It was essential to avoid any form of coercion in both recruitment as well as actual participation. This was done by placing the onus on individuals to express their interest in participating and advising them that they would not be contacted again if they did not respond. For all phases of the study, potential participants were sent an invitation letter to complete or disregard as they wished, as well as a Freepost envelope to return their reply slip to me (see Appendix 8). Once they had contacted me to express their interest in taking part, I sent them a follow up letter that included a participant information leaflet which emphasized that they would need to consent to take part and could withdraw from the study at any time without detriment (Appendix 9). They were sent a final letter of confirmation to give details of the time and date of their discussion, as well as directions to the location of the focus group and interview, if this was not taking place in their own home (see Appendix 8.3 for an example).

The participant information leaflet, sample consent form and topics for discussions leaflet were included in the invitation letter for Phase Three as participants in previous phases had expressed a preference for all of the information about the study to be included in one pack.

3.5 The participants

All the participants had undergone a lesser or a greater degree of socialisation as they had been a part of the Army population for many years (whether as a serving or a non-serving spouse). This was evident in the language that they used such as assuming knowledge of abbreviations, as well the distinctive sense of humour and terminology commonly used by those connected with the Army.

All of the study participants had had some experience of military enforced separation from their partners since becoming parents, regardless of the

phase of the study for which they were recruited. All of the serving mothers were married to serving personnel; two of the fathers were married to serving wives. The mothers had a variety of experience as a parent. For example, some were first-time mothers, others had two or more children one of whom was of primary school age (see Appendix 2). They had varying degrees of health knowledge; four had some formalised medical knowledge. For example, one mother who took part in Phase One was a paediatric nurse and another was a paramedic; one mother interviewed for Phase Two was a GP, another interviewed for Phase Three was a midwife. Five out of the seven mothers that took part in Phase Three had children under three years old, which is consistent with findings from Turnbull et al (2010) that children under five years old make up a large percentage of the calls to GPs during the out-of-hours period.

The fieldwork for Phase One and Phase Two took place in 2008 and for Phase Three in 2010, up to four years after the changes of out-of-hours provision had taken place. Participating parents had experienced a range of provision of out-of-hours service delivery depending on when they had moved to this garrison and where they had previously lived. For example, some parents had resided in the garrison during the changeover of out-of-hours service provision from the Army to the NHS, while others had moved into the garrison since the change over and had only known out-of-hours service provided by the NHS. Some participants had recently moved from British Forces Germany where the out-of-hours provision was similar to that provided by the Army in the garrison prior to 2006.

3.6 Data collection

The data collection for each phase is discussed in the following sub-sections.

3.6.1 Phase One

Four focus groups took place during April and May 2008. Denscombe (2007) recommended that focus groups should consist of between six and nine people to allow for a range of opinions and experiences, while not being so large as to inhibit each participant expressing their views. This was taken into account during recruitment and planning of the moderation of the groups. Nine participants were recruited for each focus group on the assumption that some participants may have to withdraw from the study at the last minute due to work or family commitments, which proved to be the

case. The distribution of participants within each focus group can be seen in Appendix 2.2.

The focus groups took place at a variety of times and in a selection of convenient geographical areas within walking distance of where the participants lived and worked within the garrison. Focus groups were held in the same locations as each of the different Regiments held their coffee mornings to enable most participants to be familiar with their surroundings in the anticipation that, as Holloway and Wheeler (2010) recognised, this would relax participants and so facilitate open discussion. The participants were free to choose which group was to occur at the most convenient time and location for them to attend. However in doing so, I ensured that each focus group had at least one serving parent, several mothers and a father in each group. This guaranteed that the demographics were spread across each focus group.

Krueger and Casey (2000) acknowledged the complexities involved in moderating a focus group effectively and suggested a team of two researchers so that one can concentrate on facilitating the group, while the other takes notes and attends to the practicalities such as ensuring the recorder is working effectively. An independent experienced qualitative researcher from the University of Southampton acted as scribe who had no connection to, or understanding of the Army. As Patton (2002) pointed out, taking notes has an important function not only as a backup in case the recorder malfunctions, but to aid analysis by identifying who was speaking when and to take notes of non-verbal clues that would not be included in the sound recording. In this study, using an experienced civilian researcher as scribe had the additional benefit of creating a record of objective observations and comments about the content, language and behaviour of the participants that I may have taken for granted as a serving Army mother myself.

For Phase One of the study, there was insufficient evidence to identify who might be 'typical' or 'unusual' cases, but the literature review had confirmed that military enforced separation had a major impact on the lives of Army parents. The discussion of the group was facilitated by the use of a topic guide (see Section 3.6.5 and Appendix 3).

Rationale for choosing focus groups for Phase One

Morgan (1997; 2006) advocated focus groups as a method when there is minimal evidence available. Prior to Phase One in this study, there was insufficient evidence to clarify the issues that needed to be explored in depth. Focus groups were therefore the best method to use at this point since, as Holloway and Wheeler (2010) suggested, this method facilitates communication *between* the participants (rather than between the researcher and participant). Holloway and Wheeler (2010) recognised that the stimulus that participants gain from each other in the group helps identify both their unique and shared perceptions and experiences, thus shedding light on the 'reality' of their lives and experiences. It is likely to generate more ideas or differing views than interviewing participants individually and can facilitate participants to stimulate debate and trigger thoughts that might take the discussion into an unanticipated direction while still focusing on answering the research questions.

As moderator of the focus groups, I ensured that the environment of the focus groups respected the participants' opinions and beliefs. This helped the participants to gain each other's trust and to form a rapport so that they felt more confident in opening up to each other and to me. This was essential in order to explore the issues that were important to Army mothers when their child was unwell and to develop themes for further exploration in subsequent stages of the study.

Huebner et al's (2007) use of focus groups demonstrated the benefit of using this method when there is a range of demographics within the sample population. This indicated that focus groups were a useful method to use when there is a range of military ranks and a mixture of serving and non- serving parents. Whilst Pope and Mays (2006) claimed that focus groups are typically based on homogenous samples, the differences between members of a group can be just as illuminating as the similarities. In this instance, the main commonality of all participants as Army parents contributed to the focus of discussion which reflected their shared experiences of being both parents and part of an Army environment. On the other hand, although participants of different ranks were not deliberately targeted, it was interesting to note that the serving participants held a rank ranging from corporal to major. There was no evidence that these differences inhibited the discussion in any of the four focus groups that took place in this study. The participants developed a good rapport

with each other very quickly. This generated a debate that provided rich data, irrespective of the participants' serving status, rank, whether they were a mother, father or parent of several children or just one.

It was evident that once the data analysis from the four focus groups was complete, that the impact of Army life needed to be explored in greater depth and without the risk of other participants distracting the participant who was speaking at the time from describing his or her experiences and viewpoint in depth.

3.6.2 Phase Two

The interviews took place during October and November 2008 in the participant's own home, except for one participant who requested to be interviewed in his office. Seven parents who had taken part in the focus groups for Phase One were interviewed individually using a semi-structured schedule as a guide (see Appendix 4 for interview questions). Three parents were non-serving mothers, two were serving mothers and two were serving fathers (see Appendix 2.3). Data analysis confirmed that no new themes were being generated by the time of the seventh interview and so theoretical saturation had been reached. Therefore, interviewing seven participants for this phase of the study proved sufficient.

3.6.3 Phase Three

Interviews with seven mothers who had accessed the out-of-hours clinic took place in February 2010. Six participants were non-serving mothers and one mother was serving. All six of the non-serving mothers were married to soldiers (as opposed to officers); one mother was serving, and was a junior officer who was married to another junior officer from her Regiment. One of the non-serving mothers had completed ten years' service as a soldier three years previously. All these participants had been part of the Army population for between seven to 13 years. The interviews were less structured than those in Phase Two so that the participants had as much freedom as possible to tell their own story of their experience when their child had been unwell (see Appendix 5 for interview questions). The children had suffered a variety of symptoms that caused their mothers to contact the out-of-hours clinic; the symptoms that initiated the consultation can be seen in Appendix 2.4). While the intention was to interview these parents within a month of the episode, it was not possible to arrange an interview during this time in three of the seven cases because of the mother's commitments. As in Phase One, data analysis of the

seventh interview confirmed that no new themes were being generated and so theoretical saturation had been reached. Therefore, interviewing seven participants for this phase of the study proved sufficient for this phase also.

Stake (2008) highlighted that the context can have a vital influence on the interaction in case study research. For example, the fieldwork for Phase Three of the study took place at the same time as '*Operation Moshtarak*' was in progress in Afghanistan. According to Keeble (2010), a military historian, this was the largest offensive in Afghanistan since the fall of the Taliban in 2001 and involved 9,500 British troops. Many of these troops were deployed from the garrison (the study population). As the International Council on Security and Development (2010) confirmed, the previous major offensive (called '*Operation Panther's Claw*') that had occurred June 2009, had resulted in the deaths of ten British soldiers and many others had been seriously wounded. The number of fatalities and serious injuries was anticipated to be higher in '*Operation Moshtarak*' than '*Operation Panther's Claw*' (International Council on Security and Development 2010). This created great anxiety for the mothers who participated in Phase Three of the study as many had husbands and several of their friends deployed in Afghanistan at the time that I interviewed them. Living with the fear of death and serious injury of their loved ones was a stark reality. One of the seven participants who took part in Phase Three of the study, had lost two friends who had been killed in Afghanistan, (one of whom died two days before the interview with me had taken place), and the husband of another participant had lost a leg. The impact of living with such anxiety on a daily basis dominated the mother's interviews. As a result, they gave an extremely vivid depiction of the reality of living as a non-serving wife within an Army environment when one's husband is deployed to an area where he is in grave danger. During the analysis, it was important to acknowledge the context in which the participants' narration of their experience was being undertaken. For example '*Operation Moshtarak*', which took place during Phase Three, created a considerable level of fear within the participants who might have related a different experience of their decision-making if interviewed when they were not fearful for their husband's safety.

Rationale for choosing interviews for Phases Two and Three
Interviews are not neutral tools but dynamic interactions between two people (Fontana and Frey 2008). Using interviews as a method allowed

each participant to remain focused, but also to develop and express their ideas and views in greater depth without the distraction of the other members of a focus group who may have inhibited them in sharing their true feelings (Holloway and Wheeler 2010). Holloway and Wheeler (2010) advised that the choice of location is important to enable the participants to be as relaxed as possible. Choosing to interview participants in their own homes helped them to relax and gave them the privacy to talk freely without inhibition. This also gave me an insight into life of the soldiers' families that I would not ordinarily have been able to gain as an officer, as officers and soldiers do not normally entertain each other in their own houses. This proved invaluable to enable me to gain a "*detailed insight into a specific phenomena of interest*" as Appleton (2002, p 82) recommended.

3.6.4 Development of the focus group and interview topic guides

The development of questions and a list of probes for discussion in the focus groups in the first phase related to the impact of Army life (see Appendix 3 for topic guide for Phase One). The interview schedules for Phases Two and Three were developed as themes and ideas emerged as the study progressed (see Appendix 4 for topic guide for Phase Two and Appendix 5 for the topic guide for Phase Three).

The topic guides acted as an *"aide memoire"* during each focus group and interview, as Ritchie and Lewis (2003, p 115) recommended. Using a topic guide ensured that the fieldwork remained focused on exploring the key issues to answer the research questions. Also, it enabled the same set of issues for each phase of the study to be explored, thus encouraging the varying experiences and viewpoints regarding each common issue to be examined.

Each topic guide was reviewed after the each focus group or interview to determine if 'fine tuning' of the wording of the probes was necessary for subsequent fieldwork in the same phase. Also, this ensured that the method of questioning was appropriate to the phase of the study.

Prior to the first focus group, I piloted the topic guide with fellow students and research fellows from the university to confirm whether my questions and probes were clear and likely to illicit an appropriate response. This process was helpful as it highlighted that some of the probes that I had

planned to use needed rewording. For example, I changed the question from "*what do you need the out-of-hours service to provide for you when your medical centre is closed?*" to "*how would you want the out-of-hours service to help you once you have contacted it?*"

The topic guide for Phase One built upon the existing evidence in the literature, and on what the participants identified as the features of Army life, how they impacted on the participants and what they wanted the out-of-hours service to provide for them (Appendix 3).

The topic guide for Phase Two was developed from the themes emerging from the data in Phase One and, in particular, how military enforced separation impacted on the day-to-day life of the participants (Appendix 4). Also probes explored how Army life influenced what they wanted the out-of-hours service to provide for them and how they interpreted their life as an Army parent to be different from civilian parents.

After analysing the data from Phases One and Two and undertaking an additional synthesis of the literature, it was evident that Army life, such as military enforced separation, had a significant impact on a mother's decision-making process and at a time when her child was unwell and she decided to consult a health professional during the out-of-hours period. Thus the interviews during Phase Three were geared towards mothers' descriptions of the events that led them to seek the advice of a health professional when their child had been unwell in a recent episode (Appendix 5).

3.7 Data analysis and interpretation

Data analysis was defined by Stake (1995, p 71) as "*giving meaning to first impressions as well as final compilations*". The approach to analysis depends on the theoretical perspective of the researcher; as an interpretive paradigm of constructivism was used for this study, the data were seen as "*displays of perspective*" (Silverman 2006, p 112) undertaken to increase understanding of 'the case'. From a constructivist perspective, it is not usual to adopt a theoretical framework prior to the data collection, as the whole aim of the research is to allow the theory to emerge (Appleton 2002).

Data analysis within a case study is a process that aims to enable researchers to organise and gain an intuitive grasp of the data so that they can analyse what their findings tell them about the phenomenon of interest

(Patton 2002). Data analysis for this study was undertaken using thematic analysis; categories were derived using an inductive approach and allowed to emerge from the data as patterns, themes and categories developed (Patton 2002; Pope and Mays 2006). Taking copious field notes after each focus group or interview had taken place assisted this process, as I recorded my interpretations of what was and what was not said. I had to do what Silverman (2010, p 224) called "*critical rationalism*" in that I had to discard my initial thoughts of the themes that I anticipated the data would generate.

Following a robust process for the analysis aided an accurate account of the themes and concepts to be drawn directly from the data rather than risking telling the story that I wanted to recount (see Appendix 6 for a flow diagram of the process). For example, I expected mothers to express their dissatisfaction with the distance that they had to travel to the out-of-hours clinic but did not expect to find that their husband's presence or absence had such an impact on the decisions that they made when their child was unwell.

Qualitative data analysis and interpretation are not distinct processes but are interactive and iterative as the researcher moves backwards and forwards across the data to increase understanding (Patton 2002). Analysis began during the initial collection of data for the first focus group as I tried to make sense of how the data contributed to answering the research questions. Analysis continued until the writing up process was complete as I reflected on the themes that had emerged from the data. An iterative approach to the study enabled the fieldwork to be responsive to the data as analytical themes emerged.

The "*art of interpretation*" (Stake 1995, p 12) is the insight gained by engaging in reflexivity and exploring alternative interpretations. Patton (2002) emphasized that taking field notes is essential in order to capture the researcher's descriptions, observations and intensity of feelings at the time that they occurred during the fieldwork. This was a crucial tool to enable me to record detailed descriptions about incidents and to capture thoughts that could have been forgotten during the data analysis. They were used during the fieldwork as a tool to assist the identification of how the generated data compared to the literature that was being reviewed at the time.

3.7.1 The sequence of analysis

The process of data analysis for each data set and each phase of the study followed a logical sequence that was in keeping with the interpretative approach used for the study, regardless of which phase the data originated from (see Appendix 6 for details). The following section discusses the overall strategy used to analyse the data. The data from the focus groups required an additional layer of analysis which is discussed in Section 3.7.2.

All data were audio taped and transcribed verbatim with the participants' permission. Transcribing verbatim (rather than just taking notes) ensured that all data were recorded, preventing issues from being excluded that may have proved important as themes began to emerge from the data. It also reduced the risk of any of my preconceived ideas influencing the analysis. Undertaking the process of transcription and reading the transcripts once they had been completed ensured familiarisation with the data, both soon after the collection had taken place and at a later stage during the detailed analysis. This aided coding from which an initial set of themes and categories could be developed.

Miles and Huberman (1994, p 56) described codes as *"tags or labels for assigning units of meaning to the descriptive information compiled during a study"*. Constructivism advocates using an inductive process, with the data being coded word-by-word and line-by-line, thus preventing the 'forcing' of data into a pre-existing code that may not have been appropriate (Bradley et al 2007). 'Codes' were linked to words, phrases, sentences or whole paragraphs' within the data, such as from "*I thought it was rigors"* (see Appendix 7.1). Strauss and Corbin (1998) recommended 'open' coding as it allows the researcher to use the participants' language or terminology to form the basis of a category (e.g. '*civi.*' opposed to 'civilian'). Once the data had been coded, it was possible to identify categories (See Appendix 7.2). Moving between induction and deduction was useful at this stage to confirm whether similar categories were developing in different data sets and note if any were unusual or noteworthy.

Coding the considerable volume of data enabled it to be indexed in a more manageable way as categories were identified, modified, confirmed or discarded and grouped into a hierarchical structure from which concepts could be developed. Many sections of data included multiple codes.

Simons (2009, p 144) stated that deep immersion in the data by physically moving excerpts of it around on pieces of paper encourages a greater depth of insight and understanding to be achieved, which she labels in literal terms as "*dancing with the data*". This was undertaken as the initial coding was undertaken manually by cutting and pasting the data; handling the data physically ensured an intimate knowledge of it and helped to develop the categories.

Once coding had been completed on a hard copy, it was transferred to the qualitative data analysis software package NVivo 7™. As Holloway and Wheeler (2010, p 288) suggested, this extended "*thinking*" time and helped to refine the coding. The data management tool NVivo 7™ was used to organise the data more easily and to enable some sections of text to be linked to several different codes (referred to in NVivo 7™ as unordered 'free nodes'). As categories were developed, each data set was revisited to ensure that no text relating to a category was missed. Using the '*constant comparison*' process was essential to ensure that the data were coded correctly (Pope and Mays 2006, p 78). This made it easier to recognise if there was any overlap and repetition between the categories. Once this had been done, it was possible to group the data from unordered 'free nodes' to hierarchical 'tree nodes' to facilitate category and subcategory cataloguing.

Ritchie and Lewis (2003) confirmed that it is important to ensure that connections between codes, categories and themes are tracked throughout the data and that this process is open and transparent in order to increase the trustworthiness of the study. The themes and categories that had been identified from each data set were listed so that a manageable index could be generated.

Creswell (2009) postulated that complex analysis goes beyond description and enables the identification of themes from which connections to other themes can be developed. Using the 'models' facility in NVivo 7™ to visually display new ideas helped to determine how categories were interconnected and if there was a relationship between them. From this, it was possible to develop overarching and distinct themes, for example, "*doing the right thing*" was connected to "*fear of rapid deterioration and serious illness*" (see Appendix 7.3).

Once themes had been developed, the process became more deductive as the literature was reviewed again to confirm whether the preliminary concepts were reflected therein. As Pope and Mays (2006) suggested, this involved moving backwards and forwards between the original data and the emerging interpretations. As this continued, the analysis became more focused on the process of decision-making, which led to the actual decisions that mothers made when their child was unwell, rather than focusing on the negative aspects of Army life such as 'unpredictability'. The themes generated from each data set were developed into a diagram, and compared to other data sets and to the themes identified in the literature. For example, it became evident that a mother's fear of meningitis was a common theme in both the literature and the data, but that the loss of a rational voice in the husband's absence was not a theme that was evident in the literature.

Stake (1995, p 107) advocated "*triangulation*", which he described as the process of collecting multiple sources of data or using multiple methods to reveal multiple aspects of reality to see if they are consistent with each other. Silverman (2010) advised that this minimizes misrepresentation and so increases understanding. However, the term 'triangulation' infers that the points (or reality) are fixed. Denzin and Lincoln (2008) acknowledged that a triangle has three fixed points whereas crystals produce an infinite number of shapes which depend on the angle from which they are viewed and how they are held up to the light. From a constructivist viewpoint, Denzin and Lincoln's (2008, p 7) use of the term "*crystallization*" is better suited to gaining a greater understanding of the phenomenon in this study as it reflects the multifaceted nature of reality and an individual's perception of that reality.

All the participants from Phase One confirmed that they identified strongly with the ten statements that I sent them as a summary of the findings from the focus groups. This gave confidence that the themes were developed sufficiently to allow progression to Phase Two of the study. Aside from two participants who had been relocated from the garrison, a response from all the participants provided reassurance that Army mothers remained engaged in the study. The analysis of Phase Two and a further literature review directed the completion of a topic guide for Phase Three of the study and allowed the emerging themes of a mother's decision-making to be explored in greater depth. The themes from each data set were mapped

to develop further links between them. This determined whether theoretical saturation had been reached.

'Thick' description should "*present the detail, context, emotion, and the webs of social relationships that evokes emotionality and self-feelings… the voices, feelings, actions and meanings of the interacting individuals are heard the vitality, trauma and uniqueness of the case*" (Stake 2000, p 444). Patton (2002) recognised the importance of direct quotations so that the participants are represented to the reader in their own terms; this allows the reader to project themselves into the world of the participants rather than that of the researcher's analysis. As Bryman (2004) acknowledged, much of the rich data had to be jettisoned in order to ensure that the narrative was not too descriptive. Each quote for each theme was scrutinised to ensure that the most appropriate quote for each theme and sub-theme was selected.

Holloway and Wheeler (2010) warned against coming to conclusions too quickly as this can lead to an inadequate or incomplete interpretation. Miles and Huberman (1994) confirmed that analysis continues during the process of writing up as the writer thinks through the meaning of the data, discovers new relationships and proposes explanations. Writing up the preliminary analysis enabled a *"conceptual gap"* to be identified (Bradley et al 2007, p 1759) consisting of questions that had not been foreseen earlier in the study. This focused the remainder of the fieldwork on exploring the decision-making of Army mothers when their children were unwell.

Yin (2009) stressed that case study researchers must be open to contrary findings. Pope and Mays (2006) advocated that qualitative data analysis has greater credibility if it is shown to be consistent between researchers. Once data analysis was performed, the supervisors for the study coded two transcripts independently to confirm a commonality in the coding. As Holloway and Wheeler (2010) suggested, this tested tolerance for contrary findings and ensured that the analysis came directly from the data and that the interpretation was not influenced by my own experience as an Army parent. These discussions were crucial to ensure that I was not intentionally using the case study to substantiate a preconceived position or advocate particular issues that I had predetermined prior to commencing the study.

3.7.2 Analysis of the focus groups

The focus groups generated verbatim transcripts of the discussions and I was interested in both the individual contributions of participants as well as the dynamics of the discussions. Reviewing the notes of non-verbal communication completed by the scribe as well as the field notes that I had written after each focus group played a crucial part to aid this process. I developed a matrix to identify the commonality and differences between the categories and themes being generated from each focus group. Once the first matrix was complete, I specifically looked at individual responses according to the characteristics of the participants, such as their serving status, whether they were a mother or father, parent of one child or several children, and the rank of the serving participants. This illustrated that whilst some themes related to Army life were common across all the participants, the perspectives of individuals varied. For example, although the theme "*loss of control*" was equally applicable to serving mothers and fathers, it was spoken of in different ways, depending on whether the participant was a non-serving mother or a serving father.

3.7.3 Integration of data across phases

Once the data analysis of each phase of the study was complete, the contents of each matrix from that phase were merged so that the themes that had been generated from that phase could be seen visually in a table. All the themes generated from all phases were then combined. As Pope and Mays (2006) acknowledged, this involved a considerable amount of synthesis with themes displayed across the columns and each data set in a different row. A final matrix was developed which mapped each theme against each group of participants to identify if particular themes were generated by individuals with specific characteristics, such as whether a mother or a father or serving or non-serving.

Each theme was reviewed to determine how dominant it was in each phase and how it was interpreted by the participants. Patterns of commonality, differences, and contradictions between each data set for each phase and explanations for this were identified, a process described by Yin (2009) as pattern matching. For example, it was clear from reviewing the theme of 'access' via face-to-face or telephone, that all participants preferred face-to-face contact, but some highlighted the benefits of telephone access. Once a further in-depth analysis had been undertaken, it was evident that it was

the non-serving mothers without access to transport who particularly identified the benefits of telephone access.

Combining the data from across phases enabled me to identify what participants were telling me about the impact of Army life and interpret how it had a bearing on the decisions that mothers made when their child was unwell.

3.8 Ethical issues

Protection of the dignity, right, safety and wellbeing of participants is paramount (Holloway and Wheeler 2010). I protected the participants from any physical or emotional distress or any other kind of harm to the best of my ability. As Stake (1995) pointed out, I also had an ethical obligation to minimise misrepresentation and misunderstanding as well as to protect the participants from any harm.

Following a stringent peer review, the Ministry of Defence Research Ethics Committee (MoD REC) (Reference 0744/129) granted ethical approval. Phase One received ethical approval in July 2007 and an amendment for the recruitment procedure was approved December 2007. Phase Two received ethical clearance in September 2008 and Phase Three in November 2009.

3.8.1 Avoidance of coercion

To avoid coercion, it was essential that participants were invited to take part by those who were not part of the study and had no conflicting interests in it. Potential participants were aware that they were free to withdraw from the study at any time without consequence and could contact me whenever they required further clarification. They were given at least a week from being approached initially to reflect on whether they wished to take part in the study. During data gathering, participants knew that they could end the discussion or interview at any time if they wished to do so. Also, their participation in the study could be retracted and they could request that their contribution was halted and erased at any stage (although none did). Potential participants who were invited to take part but declined (including by non-response) were not contacted again (see Appendix 9 for Participant Information Leaflets). Also, using the Army nurses and the Unit Welfare Officers as facilitators for recruitment avoided the risk of me as the researcher being seen to coerce participants to take part.

I had contact with the participants in my capacity as a researcher only and not in my role as a nurse, midwife, officer, mother or health professional. I wore casual civilian clothes at all times to avoid a potential conflict of interest and to reduce the influence that my rank may have had on the participants if they had known that I was an officer while many of them were soldiers or married to soldiers. All electronic mail correspondence was to a University of Southampton account rather than to an Army electronic mail account and all telephone communication was to a mobile telephone.

3.8.2 Informed consent

The Army nurses and Unit Welfare Officers included a sample consent form with the invitation letter that they sent to the potential participants. On the same day as a focus group took place and just prior to the focus groups commencing, the participants completed a consent form with the scribe acting as witness for the participants' signatures. Consent forms for the interviewees were sent out prior to the interview to allow the participant time to get their signature witnessed. A sample consent form can be seen in Appendix 10.

Participants were given the opportunity to ask questions and to confirm that they consented to be recorded both prior to and following any interview or focus group. Afterwards they were invited to comment on whether logistical aspects could be improved.

3.8.3 Confidentiality and anonymity

All participants were reassured that their contribution was confidential, that the information collected was anonymous and it would be stored in a safe place. Reassurance that confidentiality and anonymity would be maintained for the participants was paramount in this study. In common with other military studies (such as Giles 2005; Dandeker et al 2006 and Clifton 2007), this reassurance reduced apprehension that any criticism of the British Army might be attributed to them and result in some form of retribution from either their superiors or their husband's superiors. They were advised that the only circumstance in which confidentiality would have to be broken would be if there was evidence that the safety of vulnerable adults, children or the participant was at risk, in which case relevant information would need to be disclosed to an appropriate third party; this situation did not occur.

As Kitzinger (1995) recommended, the focus group participants were advised not to discuss the contents of the discussion with anyone outside the group once it was over so that the confidentiality of the other individuals taking part was not compromised. All the serving participants that attended the focus group were requested to do so in civilian clothes in case visual identity of their rank on their uniform influenced the discussion and inhibited the contribution of other participants.

All the data have been stored and treated in compliance with The Data Protection Act 1998 (The National Archives 2010). The audio tapes of the focus groups and interviews have been stored in a locked cabinet, to which only my supervisors and I have had access. Personal identifiable data (i.e. participant names and contact details) has been stored separately from the anonymous interview data as hard copies only. Only anonymous data and demographic information have been stored on a computer and this has been password protected. The data have been archived in locked premises at the University of Southampton for ten years during which time the Research Office within the School of Health Sciences will act as custodian. After this period, the Ministry of Defence will review whether it wishes to store the data securely for a further five years or destroy it in accordance with Ministry of Defence policy (Ministry of Defence 2006).

3.8.4 Protection from harm

Fontana and Frey (2008) acknowledged that there is an increasing realisation that researchers are not impartial, but in fact are seen as active participants as they interact with their study participants. Throughout the fieldwork, I gave positive non-verbal feedback to encourage the participants to express their views freely without the fear of being judged. Holloway and Wheeler (2010) stressed that researchers must be prepared to support participants as they reveal their experiences and deep thoughts, particularly as they may become aware of hidden feelings for the first time. While the issues debated in the focus groups were passionate, they did not have the intensity of some of the stories that the mothers told me in their one-to-one interviews. This confirmed that the data collection strategy was appropriate and that different data collection methods provoke different forms of disclosure. I was shocked by the level of the mothers' distress and the strength and power of their accounts in the interviews as they recounted their experiences of Army life and how it impacted on the decisions they made when their child was unwell.

Prior and during each one-to-one interview, participants were asked whether they wanted the recorder to be turned off if they became upset, but none of them did. One wanted me to record her sobs, to emphasize the strength of the personal distress that aspects of Army life had caused her. When a mother became upset, I did not stop the interview immediately but paused to allow her sufficient time to gather her emotions. I did not want to cause her any more distress by continuing with the interview if she did not want me to do so, but also did not want to signal that I was not interested in what she had to say or that I was not giving her permission to express her distress by turning off the recorder immediately. Hearing and acknowledging the participants' distress seemed a powerful part of the story that they wanted me to witness. I did my best to give psychological support once the interview was over. While I was interviewing the participants in my capacity as a researcher, it would have been ethically wrong of me not to use the psychological support skills that I had learnt as a clinician to ensure that I left the participants in an appropriate emotional and mental state. I offered to refer them for further psychological support; none of them requested me to do so.

3.9 Assessing the quality of the study

Saukko (2008) emphasized that the quality of a study is dependent on how thoroughly and defensibly it has been undertaken. Constructivism dictates that a study's trustworthiness, dependability, credibility, transferability and conformability must be transparent to enable readers to assess its worthiness. Lincoln and Guba (2000) developed the concepts of trustworthiness and authenticity while Silverman (2010) highlighted the importance of reliability due to the high risk of subjectivity in qualitative research. As Stake (2000) pointed out, this is particularly important within a qualitative case study as this is highly personal research in which interaction between the researcher and participants is unique and not easily reproducible by other researchers; also the researcher is giving his or her own interpretation of the case.

Stake (1995) stressed that the strength of a qualitative case study is the meaning and understanding that it generates, not the reproducibility that occurs in quantitative studies. The study design of this investigation allowed me to be an integral part of the research process and data collection. Giving my constructivist viewpoint at the beginning of this chapter has allowed the reader to identify the 'lens' of constructivism

through which this study has been undertaken. Guba and Lincoln (2008, p 274) acknowledged the importance of giving sufficient description to illuminate the case and give the study its "*authenticity*". The next chapter gives direct quotations to illustrate the themes that have emerged and to take the reader into the world of the participants.

Getting to know the participants 'in the field' and involving myself in their world of Regimental coffee mornings and parent and toddler groups seemed to increase my credibility in the eyes of the participants who undertook the research. They expressed their confidence in me to interpret their views accurately. Their willingness to talk so candidly to me about their experiences demonstrated that they felt secure that I would not divulge any of the information that they had given me to their own (if serving) military line managers or their serving husband's 'Chain of Command' (see Army terminology).

The transparency of my study design enables the reader to evaluate the decisions that I have made and give credibility to the research – termed by Denzin and Lincoln (2005 p 21) as "*confirmability*". My supervisors, experienced qualitative researchers in their own right, have scrutinised every stage of this study. Undergoing an ethical review ensured transparency also.

The interpretation, understanding and conclusions generated from my findings may have implications beyond the small number of participants that have taken part in this study. Stake (1995, p 8) talked of "*particularisation*" rather than generalisation. I have chosen a particular case (Army parents and mothers) in order to understand its complexities and uniqueness rather than generalising it to others. Theoretical generalisation supports the transferability of the findings to health care providers caring for other Service families or mothers within other social contexts and settings, such as the families of prisoners who are also undergoing enforced separation, regardless of the characteristics of the separation.

Finally, my professional values from many years as a nurse and midwife have instilled in me a natural moral responsibility and passion to endeavour to accurately represent the participants to the best of my ability and in doing so, maximise the quality of this study.

3.10 Reflexivity

Holloway and Wheeler (2010) recognised that reflexivity involves a process of self-awareness that should clarify how one's beliefs and viewpoint are influencing the research. The objectivity of quantitative research means that the quantitative researcher pays little attention to the impact that this may have upon the research process. In this qualitative case study, critical self - analytical scrutiny was important to identify if my own roles of Army mother, wife, officer and health professional were influencing the study. I am embedded within the Army, which meant that I had undergone a similar socialisation process to my participants.

The participants were aware of my identity as a nurse, midwife, mother, serving member and that my husband had served in the Army. Naturally incorporating the same military terminology, expressions and language demonstrated to the participants that I was part of their Army world, for example using terms such as 'R and R' for 'rest and recuperation' and 'civi.' for 'civilian'. The language, phrases and military terminology that they used indicated that they perceived that I was not that different to them and that my own experience would enable me to relate to and understand their viewpoint. It is possible that this permitted mothers to display their vulnerability to me, something that they may not have been prepared to do to a complete outsider.

Richards and Emslie (2000) argued that the participants' preconception of the roles of researchers influences the contents of an interview. They recognised that participants disclosed more health-related information to researchers who were GPs than those who were sociologists. As Chew-Graham et al (2002) pointed out, it was essential to identify whether my identity as a serving mother and a health professional had influenced the information that participants gave me. I never wore uniform in the participants' presence or told them my rank. I had to be aware of the power relationship that being an officer within a two-tiered Army population of soldier and officer created, as some of the participants were serving and may have assumed what rank I was even if I had not told them.

"*Experience affects perspective while perspective shapes experience*" (Patton 2002, p 335). I am an 'insider' as I am an Army parent with the experience of remaining at home with a young child during my husband's deployment. Being an 'insider' enabled me to exploit areas of enquiry that may have not

been apparent to researchers who have no experience of either Army life or that or being a parent. Although I was not undertaking formal participant observation as a data collection method, I still wished to develop an insider's view of the participants, an 'emic' perspective, so that I could gain a greater understanding of what life was like for them (Patton 2002). The personal contact that I had with them, whether by telephone or when meeting them during recruitment, was very important in order to develop a rapport and build up their trust to enable them to 'open up' to me (Ryan and Golden 2006; Holloway and Wheeler 2010).

While I saw myself as an 'insider', I was an 'outsider' to the majority of participants as they were non-serving Regimental Army wives and full time carers for their children. Unlike many of the participants, I am serving with a Corps not a Regiment and I work full time, I live in my own house rather than Army accommodation and I have one child only. My position is depicted in Figure 3.2.

Figure 3-2 'Insider' versus 'outsider'
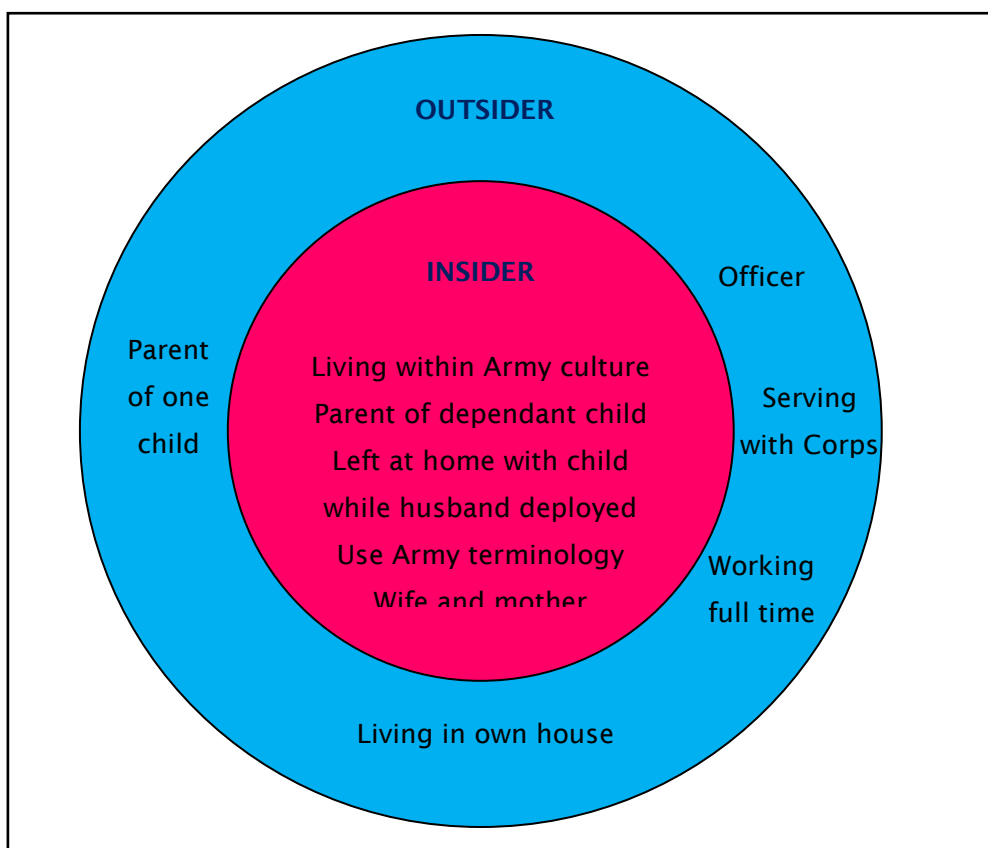
Figure 3.2 demonstrates that while in some ways I was in a similar situation to the participants, there were fundamental differences that may have altered my perspective. Patton (2002) stressed the methodological

importance of doing justice to both 'etic' and 'emic' perspectives and being clear how to manage this tension. I had to ensure that I maintained an 'emic perspective' when examining the perceptions and experiences of Army parents without imposing my pre-judgment which may have distorted the ideas of the participants of what Army life is like. On the other hand, I had my own interpretation, the outsider's 'etic perspective' (Holloway and Wheeler 2010). I had to be open and reflexive as well as objective in order to develop knowledge, understanding and insight into the 'world' of the participants to ensure that prior assumptions that I had gained through my experience and from the literature did not influence my thinking about the phenomenon (Holloway and Wheeler 2010).

Reflection upon the complexity of my own decision-making when my daughter had been unwell, and the vulnerability that I had felt as an Army mother during my husband's deployment helped me to gain further insight into the experience of the participants. This, along with the literature reviewed, the fieldwork and the analysis helped me to interpret what was being said by the participants and to compare my impressions against the verbatim transcripts.

3.11 Summary of chapter

Using constructivism and a case study approach provided a framework to develop an understanding of the influence that Army life has on the lives of Army parents and how Army life influences the decisions that mothers make when their child is unwell. Knowledge of the approach used in the study and my interpretation of case study design have directed all stages of the study, from the development of the research questions and the identification of boundaries to the choice of data collection methods and the process of analysis. This has provided a framework to exploit the data to increase the understanding of the case and phenomenon of interest. Perception is subject to different interpretations and what may seem 'real' to one person may not seem 'real' to another. Interviewing parents with a variety of different demographics[1] in Phase One and Phase Two, followed by interviewing mothers alone for Phase Three, gave me a far greater insight into the phenomenon and of the multiple realities of Army parents than if only non-serving mothers had been included in the study. Hearing the

---

[1] e.g. serving and non-serving, father and mother, parent of several children or only one

experiences of Army parents made me engage in reflexivity and self-reflection to ascertain how my life was different to theirs and how my experience and beliefs may have influenced the study. An awareness of robust ethical procedures was crucial to protect the participants from harm. The next chapter focuses on the study findings.

Chapter 4 Findings - Army life and the decision to consult

4.1 Introduction

This chapter reports the findings of the study. Section One focuses on the findings regarding the impact of Army life, whilst Section Two presents the findings related to the decisions that mothers make when their child is unwell as well as their expectations for support from the out-of-hours service.

It became clear as the data analysis progressed, that Army life was integral to the decisions that mothers made when their child was unwell and that the findings needed to be reported in terms of the themes that had emerged, rather than phase by phase or according to the research questions. Therefore, this chapter presents the findings according to the themes listed in Table 4.1 and Table 4.2.

Section One relates the findings to the features of Army life that impacted on Army parents. The themes are presented in three sections – coping strategies (Section 4.2), the impact of frequent relocation (Section 4.3) and the impact of military enforced separation (Section 4.4) and are illustrated in Table 4.1.

Table 4-1 Section One: Themes identified

Section One: Features of Army life and their impact on parents
Coping strategies   • Need for flexibility   • Need for resilience   • Need for trust   • Need for an identity   • Allegiance to the Army   **Impact of frequent relocation**   • Unpredictability of relocation   • Re-establishing a support network   • Welfare support   **Impact of military enforced separation**   • Types of separation   • Frequency   • Notice of deployment   • The pre-deployment phase   • Separation phase   • The post-deployment phase

Section Two reports the findings related to the features that influenced the mother's decision to consult when her child was unwell. The findings are presented in three sections also - mother as protector (Section 4.5), use of out of hours

(Section 4.6) services and impact of husband's presence or absence (Section 4.7).
These are illustrated in Table 4.2.

Table 4-2 Section Two: Themes identified

Section Two: The decision to consult
Mother as protector
• Making sense of the illness or injury
• Fear of rapid deterioration and serious illness
• Doing the right thing
• Fear of accessing services inappropriately
• Inequity of service provision
Use of out-of-hours services
• Accessing an appropriate service
• Weighing up the options
• Algorithms for triage
• Expectations of the out-of-hours service
Impact of husband's presence or absence
• First or last resort
• An accumulation of stressors

The mothers' viewpoints dominated the findings as 27 of the 31 parents who participated in the study were mothers. These demographics reflected participant profiles identified in the military literature (such as Giles 2005; Huebner et al 2007; Clifton 2007) in which the majority of participants were non- serving mothers. However, the four fathers who took part gave a valuable insight from the perspective of a serving Army father and were keen to represent what they anticipated their wife's point of view would be also. Their willingness to participate in the study and to give such a candid description of their experiences, confirmed that health care for their family was important to them. This was particularly the case during times of deployment as this necessitated leaving their wife as the principal carer for their children.

Table 4.3 illustrates the codes that were used to identify the originator of the data.

Table 4-3 Coding to identify the originator of the finding

Method	Phase	Serving status whether mother or father	Identification of participant	Symbols
G = Focus Group Iv = Interview	(1) Phase One (2) Phase Two (3) Phase Three	SM - Serving Mother NM - Non-Serving Mother F - Serving Father (all fathers were serving)	: Number - Anonymous identification number of Participant	Brackets ([ ]) within the direct quote to insert the context or explanation to ensure anonymity maintained.

For example - Iv(3) NM:26 is an excerpt from an interview from Phase Three with a non-serving mother who was anonymous as Participant 26. The participants serving status is not referred to in the narrative unless it is relevant to a particular finding. Further details of the participants' demographics are given in Appendix 2.

Section One - Features of Army life and their impact on parents

Parents emphasized that disruption was so embedded in every aspect of Army life that it was necessary to develop many strategies to enable them to cope with the daily challenges that they had to face. Disruption took many forms and varied from the daily disruption of the serving spouse needing to work late at short notice, to little warning of training exercises, courses, relocation or deployment. The disruption affecting the serving member of the family made it difficult for the rest of the family to plan because any sudden changes of events affected the whole the family and had a direct impact both psychologically and in practical terms.

4.2 Coping strategies

Disruption seemed embedded in all aspects of their lives and took many forms. Sudden changes of plan prevented the ability to plan in the short, medium and long-term, frequent relocation caused a nomadic existence that created feelings of 'rootlessness', while deployment altered the family's dynamics which meant that they had to be flexible at all times. Relocation and military enforced separation caused such major disruption for all the family that their impact demands a section of this chapter in their own right (Section 4.3 and Section 4.4). Parents talked of the constant emotional upheaval in their lives and the importance of coping strategies such as resilience, which they developed in order to deal with the challenges that they had to face. This was stark evidence that these mothers resigned themselves to having to deal with whatever situation the Army exposed them to. They acknowledged that it was part of their role to support their husband as part of upholding the Military Covenant.

4.2.1 Need for flexibility

All parents, irrespective of their serving status or rank if serving, expressed their frustration that their family plans were frequently disrupted and had to be changed at the last minute. This was because the nature and time of any Army work related events, such as training exercises, deployments and house moves, would alter without warning or their consent. Most of the non-serving mothers accepted that disruption and the need for flexibility was a part of Army life. However, they were intolerant of the constant alterations to plans that affected the whole family. All of the participants described an inability to control events in their daily lives and of the difficulties in planning short, medium or long term for their family, as this non-serving mother stated:

> You have no certainty about anything. The Army just decided, out of thin air he [serving husband] told me – 'I'm going on exercises for four days!' Which

has totally messed up your weekend plans, but that's just always happening. You've got to be ready to just drop everything.

<div align="right">Iv(2) NM:26</div>

Such an inability to plan short term made the establishment of a routine quite difficult.

We make plans to do something and then it gets disrupted because the Army then changes the week or the date. Suddenly it all goes topsy-turvey because they say 'oh we're going away next week' which happened to me this week - 'We are going away four days early'. So all our plans of what we were going to do have to be cancelled.

<div align="right">G(1) NM:5</div>

The Army even altered relocation to a new post at short notice.

The Army changed my posting at the last minute. I found out two weeks before I was starting work that I wasn't going where I was supposed to be going. I'd had child minding, and a crèche and everything sorted out and then due to posting I had to cancel everything, rearrange everything and start all over again. I was supposed to go to [name of garrison] *and I found out that I wasn't going there, but they didn't tell me where I was going instead, so I had the worry about thinking - 'Oh my God they are going to send me to anywhere, North of England, Scotland, wherever'.*

<div align="right">Iv(2) SM:19</div>

Mothers at home had no idea whether their serving husbands would be home to help with childcare or even if their husband would be home that night. Some mothers talked of dealing with this by making short-term plans that included their husbands. Others had learnt from experience that this was a waste of time and coped by by-passing their husband all together and assumed that their husband would not be home to provide any practical support.

I just don't rely on him [serving husband] *to be there for any childcare whatsoever. The minute I try to arrange something, or organise something round him he says – 'I'm on duty now and I'm doing this and doing that', so it's just easier to completely bypass him and sort it out myself.*

<div align="right">G(1) NM:14</div>

They expressed an aspiration that serving personnel should work a "*normal*" working week Monday to Friday 0800 to 1700 hours when working within the garrison to compensate for the disruption and long hours worked during training

<div align="center">111</div>

courses and deployments away from the garrison. In practice, Army personnel had little control over when they would be called into work, which really limited their time together as a family.

> *Soldiers are paid 24-hours a day, seven days a week. So, I could be called away, I am running a 24-hour facility, my* [serving] *wife runs a 24-hour facility, so either or both of us could be called out at any minute, any time, any day, any weather, and I believe that that is slightly different from a normal civi*[lian] *life when two parents are working.*

> G(1) SF:22

However, female serving mothers talked of Army line managers who tried their best to compensate for the disruption by allowing their soldiers to finish early if work pressures allowed it.

> *I think the Army is pretty good about letting you off; my boss is pretty good anyway.*

> Iv(2) SM:19

Serving mothers spoke of the compassion and kindness of their male Army line managers who had willingly given them time off from work when their child had been ill.

> *When my son has been poorly work had been really good with me about taking time off. I think the Army is very good at letting people go home or take a bit of buckshee time off which often isn't counted against annual leave or anything formal if the child is ill.*

> Iv(2) SM:20

A serving father gave a different perspective and talked of being disciplined if he was late for work because he had to take his child to day-care or school. None of the fathers talked of being given time off when their child was unwell, and one perceived this as discrimination.

> *Although we say the Army is equal opportunities it's harder for men to get time off. The bosses are still dinosaurs – 'You are a female clerk, go and get your daughter from nursery!' Whereas the blokes – 'What do you mean? No! That's your wife's job!'*

> G(1) SF21

They considered that working such unpredictable and potentially long working hours could be an additional demand that was different to civilian employment.

The biggest thing is you cannot make plans because even like coming for this interview is all planned out a week in advance, weeks in advance, and bang – got a conference, working late. Not like civi[lian]s where at five o'clock you knock off and walk out the door, in the Army you work late all the time and it's expected.

<div align="right">Iv(2) SF:23</div>

The serving participants expressed appreciation of how tolerant their own wives were of their workload and circumstances and compared them to their less tolerant friends.

My second in command's wife rings up at five every night and asks where he is, if he's still there at six, he gets another 'phone call and then he goes home. I think his wife is slightly unfair actually because that is actually part of the job spec for a second in command of a Regiment like his to work late, especially when they are on operations.

<div align="right">Iv(2) SF:24</div>

These wives seemed very protective of their serving husband's off duty time, particularly when witnessing constant disruption at home from work calls that they deemed were unnecessary.

It's a permanent work process for him because he's so pressurized and the phone is always ringing, and so and so is always ringing to tell him a bit of information – it's information that isn't necessary at eight o'clock at night, it could wait until the next day. But that sends him off in a spin and off we go again and off he goes back to work and you just think that's a huge amount of pressure on an individual.

<div align="right">G(1) NM:5</div>

This made the time that they did manage to have together as a family even more valuable. As a result, they seemed very respectful of the limited family time that other Army families might be enjoying together and talked of being conscious of not wanting to disturb their friends at such a time.

Weekends I wouldn't go to see her anyway because she's with her family and I'd hate to disturb her.

<div align="right">Iv(2) NM:2</div>

Living in military married accommodation according to rank did have the advantage that serving personnel were of a comparable age and so neighbours were often in a similar life stage to each other. This meant that many neighbours had children of

the same age, which helped to develop a mutually supportive environment and a "*common bond*" between Army families. Mothers stressed the importance of offering each other practical and emotional support, they found this very reassuring and appreciated it was a benefit that may not occur in civilian communities.

> *I think it's hard in civi*[lian] *life to realise how much you rely on your friends and your neighbours, to be able to knock on someone's door. My civi*[lian] *friends just cannot grasp that whatsoever, when they're* [husbands] *away for six months, they* [neighbours] *are your family as the majority of us do not have family down here anyway.*
>
> G(1) NM:12

They commented on the friendliness within Army communities compared to civilian ones.

> *Army communities and things, people are much more friendly. People you've never met before are much more likely to knock on your door and say – 'You're on your own can I mow your lawn or here's a plate of dinner, or bring your children round'. I was on my own last week and had to go to A and E, and I kind of walked out the house and I was like - 'Right who is in?' and I knew that I could knock on any door up and down the road, and anyone would have the other children to help me. I think where my parents live they don't know their neighbours.*
>
> Iv(2) NM:1

4.2.2 Need for resilience

Fathers talked of how proud they were that their wives "*coped*" so well with all of the challenges that they had to face as a non-serving parent within an Army community. Non-serving mothers were keen to demonstrate their resilience in coping with the challenges that they perceived they faced, but which they assumed that neither their civilian counterparts nor serving spouse had to contend with. Many compared their lives to those of their childhood friends and family still living in the town from where they originated, and how much more straightforward their lives appeared to be in contrast to their own. They talked of having to develop an inner strength, of being "*strong*" and a "*resilient person*" and of being able to "*bounce back*" to survive. They acknowledged that this need for survival gave them an identity and made them "*different*" from "*normal*" civilian mothers who had nothing to do with the Services and whom they perceived did not have to face so many challenges. The longer they had been part of the Army population the more resilient they had become.

> *It's weird. I have become stronger because of the unfortunate circumstances we've had to be put into in the Army 'cause it's just a completely different*

world in the Army. I go home and my friends haven't left North Wales, they just let life go by, they've got nothing to deal with - we get hit with bigger things like soldiers being killed and I don't know if they could cope with it. Things that might not happen in a little quiet village in North Wales you know. The longer you're in it [the Army population] *the stronger and* [emotionally] *tougher you become.*

Iv(3) NM:27

They recognised that they faced additional challenges such as separation and relocation.

You have to learn to cope in Army life. You have to learn to deal with things. You have to get on with it , bounce back for the sake of the children. It's part of Army life to cope; you've got to.

Iv(2) NM:2

These mothers seemed to accept that fearing the death and serious injury of their deployed husband and friends was a reality and a risk of Army life. One even spoke of planning her husband's funeral with him before he deployed in case he did not return. The level of worry and fear for their husband's safety which they experienced differentiated their situation from the employment-enforced separation that civilian families experienced.

All you've got to do is watch the news to see the casualties returning from Afghanistan. And while their husband is away, some of the wives sit there and watches that every day and sees soldiers being injured and being killed, and it is a massive difference to anything that any civi[lian] employment comes up against; not the fact that your husband's away, but that his life is in danger.

Iv(2) SM:19

Parents talked of different types of isolation depending on whether they were from a Regiment or a Corps. All talked of being isolated from the rest of society, of being in *"their own bubble"* within a military environment. They also talked of being geographically isolated and that Army camps were often located "*miles from anywhere*" which made access to services very difficult. Loneliness seemed a more prominent emotion displayed by the mothers of pre-school children that took part in this study, particularly during times of deployment when they craved adult company and conversation. One participant was so lonely that she used to watch the news for adult company even though it might contain some frightening information about her husband's deployment.

> *If it's been raining all day and you've not seen any adults, it's almost like a companion to watch the news, just listen to other adults speaking about things that make sense to you when there is no one else in the house other than the kids.*
>
> Iv(2) NM:6

4.2.3 Need for trust

Most of the participants talked of the trust within Army communities, which meant that they could call on other parents to help in a time of crisis, even if they had not met them.

> *I think the upside is whenever you do move house, my wife likes that security to know she can go to strangers and they'll help her, 'cause everyone is – you are all in the same boat. That's what's different –you couldn't do that go to strangers for help in civi*[lian] *Street because if you don't know somebody you don't talk to them do you?*
>
> G(1) SF:23

However one mother gave an alternative view and acknowledged that her Army neighbours were no substitute for her lifelong friends from their hometown who she could really trust and whom she described as her *"forever friends,"* compared to her local Army friends she perceived to be her "*playgroup friends*".

> *You don't really trust anyone and you don't really have your family or friends around you unlike back at home in Wales. I don't think you can talk to anyone like you would your best mate back home in Wales I've known for 24 years, I can talk to her about anything. I wouldn't open up to my next door neighbour.*
>
> Iv(2) NM:2

4.2.4 Need for an identity

All of the serving personnel bar one (who was on maternity leave and planning to leave the Army) attended the focus groups in Army uniform despite my request not to do so prior to the focus groups taking place. However, the data generated from the discussions demonstrated that this did not inhibit the contribution of the other participants, even in the groups that had mixed ranks and both officers and soldiers. Wearing uniform gave a clear message that serving parents wanted to make their serving status clear irrespective of whether a mother or father, or whether or not they were an officer or soldier.

All of the participants used "*Army Wives" or "the wives"*" as a generic descriptor for any female spouse of a serving soldier regardless of their serving status. It was

impossible to ascertain from this term whether they were referring to a mother, a childless wife or whether the wife was serving or not. The way in which serving mothers described themselves as an "*Army wife*" also indicated that their role as a 'wife' took precedence over their serving role. Mothers in this study acknowledged that using the term "*Army wife*" gave them an identity of "*coping with a Blitz mentality*" and that all wives within the Army should be proud of being part of such a group. This made them part of a "*different*", "*tougher*", "*stronger*" and distinctive group that was able to rise above the considerable challenges that the Army presented them with.

> *I call myself an Army wife because that is what we all are. That's what makes us different from the wife of the manager of Barclays. We are different. We have to be stronger. We have to cope with a different set of problems to civilians because our lives are different.*

<div align="right">Iv(2) NM:1</div>

It was evident that the strict rank structure of the Army influenced all aspects of family life from the type of allocated housing to their opportunities for developing friendships. Mothers whose husbands were of a similar rank to each other accepted that being allocated married accommodation in the same geographical area of the garrison was a normal part of military life. None spoke of mixing with families whose husbands were of a different rank and who lived in different accommodation areas. Some found that a few non-serving wives used their husband's rank as a tool to make themselves appear superior to other wives, despite not having a rank themselves.

> *Women carry their husband's ranks don't they? I don't have any friends whose husbands are higher up than corporal like my husband – I find the higher the husband's go the more their wives look down on other wives, and I'm just not like that. One woman her husband is a WO2* [of rank Warrant Officer Class 2] *and another one he's a Sergeant and they won't really mix with us because our husbands are corporals!*

<div align="right">Iv(2) NM:6</div>

Not only were they accommodated in different geographical areas according to rank, but I witnessed a great variety in the quality and size of the housing as I undertook the interviews in participant's homes. The officers' married accommodation areas (for captains and majors) that I encountered were all spacious three or four bedroom houses with large kitchens, separate dining rooms and living areas, as well as spacious gardens which backed onto the wide-open spaces of military scrubland. The soldier's houses for corporals to staff sergeants were much

smaller, with small combined living and dining areas and tiny gardens only large enough for a rotary washing line. Soldiers' married accommodation was located in large housing estates near main roads and often with graffiti on the walls. However, most of the participants who were soldiers or wives of soldiers had been serving in the Army for much longer (for up to 22 years in some cases) than the officers and officers' wives, whose average length of service was eight years. The marked difference in the quality and size of the accommodation demonstrated that rank had a major impact on the family's entitlement. The lack of acknowledgement of the number of times that a soldier had risked his life on military duty made me question how much society really values Army families as an excerpt from my field notes demonstrates.

> *The interview I undertook last week was with a wife of an officer who had been serving for 8 years. Her interview took place in her spacious dining room and looked over her large garden with a large trampoline and space for an adventure playground. This week I interviewed a wife of a staff sergeant in her tiny living area with enough room for a small sofa and television (no separate dining room here!), her garden was only big enough for a rotary clothesline. Her husband was about to complete 22 years' service. When I arrived, she offered me a cup of coffee and had to go out to the garage, as the kitchen was too small to accommodate her fridge. This mother is trying to cope with two children under 3 years old while her husband is away just like any other Army wife in her situation. Her husband has risked his life on many occasions for the Army and yet because of her husband's rank, she has to go to her garage to get her milk, as her kitchen is not big enough for a fridge.*
>
> Excerpt from field notes 17 October 2008

The non-serving mothers that took part expressed independently that they thought of themselves as neither civilian nor military but "*in-between*". They expressed the view that the Army did not perceive them as serving, as they did not hold a rank, but that their Army lifestyle prevented the local civilian community from considering them as civilians.

> *We are not totally civi*[lian]*s because we are attached to the Army; we are kind of neither one nor the other. I am not in the Army, I don't have a rank, I don't have an Army job,* [but] *I probably know more about the Army than the average civi[lian] does. I just think we are kind of in between.*
>
> G(1) NM:12

However, while the non-serving participants perceived that they were 'different', they did not want to be treated differently and wanted others to be clear of their civilian, non-military status.

> *I'm a civilian, my husband is the military! So, yeah, just treat me like you would anyone else, and you know there's no point in treating us any different just because my husband's in the Army.*

<div align="right">Iv(2) NM:2</div>

4.2.5 Allegiance to the Army

The majority of participants talked of the tension caused by dividing their loyalties between the Army and their own family. All acknowledged that the Army's culture dictated that its needs as an organisation took priority over those of the family (Ministry of Defence 2010b, p 3). In practice, this meant that the Army demanded acceptance of disruption and constant change in return for providing financial security; this was in direct conflict with the needs of the family who craved stability and continuity and this created internal emotional conflict for all the participants. As part of this, these mothers acknowledged that they provided vital emotional and practical support for their husbands, but expressed their frustration that this diminished their control over events and led them to believe that they were of secondary importance to their husband.

> *It's not our choice where we go. We chose to marry a soldier, but at the end of the day, they get told where to go and we follow.*

<div align="right">G(1) NM:10</div>

Both serving fathers and mothers accepted that the needs of the Army must come first, but this did not make it easy in practice. The serving mothers believed that their greater insight and understanding of their husband's role and responsibilities than their non-serving friends had helped them to accept situations when the needs of the Army had to override their personal needs. For example, one serving mother who took part had accepted and presumed that her husband would put his duty of leaving for deployment on time above even attending the birth of their daughter.

> *It was looking most likely that he'd* [husband] *miss the delivery and that because he was going out as Battery Commander to Iraq. He felt a lot of responsibility to be there for his guys* [soldiers that he was leading] *and not be going out late or anything like that. So that was quite hard for me. He had soldiers in a similar situation when arrangements were being made to allow them to be home, or to get them back or whatever. But I knew from my own experience of deployments and what it's like that through pride in his work and wanting to the there for his guys that he would have an internal struggle*

with trying to do the same for himself, so I guess my own Army experience
helped me to understand his dilemma.

<div align="right">G(1) SM:20</div>

Both serving mothers and fathers talked of times when divided loyalties had been so great that they had considered leaving the Army. Serving fathers seemed better able to make compromises than the serving mothers did. Nevertheless, fathers expressed guilt that their allegiance to the Army was putting their family through such emotional turmoil. They wrestled with the need to provide financial security for the family by remaining in the Army versus attaining geographical stability, particularly once their children were of school age. The stability of schooling became such a priority for them that one father was prepared to become 'voluntarily unaccompanied' This meant that he had chosen to be separated from his family in the week and commuted to his permanent home at weekends to ensure stability of education for his daughter in his home town (see Army terminology and definitions). The financial stability provided by a secure military income took greater saliency as they got older:

> *It was very important for us that she has one school which is very stable, she's*
> *not going to move, which would happen in the Army environment. So it was*
> *important that we got her settled in a school, which really basically, my hands*
> *were tied, I had no other decision other than to become married*
> *unaccompanied, or leave the Army. So me and my wife decided that it would*
> *be better that we continued for that financial stability really for our family.*

<div align="right">Iv(2) SF:24</div>

All the serving mothers talked of a dramatic increase in their level of emotional turmoil since they had had children. The Army expected their allegiance to remain to the Army; in practice, their loyalty had altered to ensuring that their child's needs were their utmost priority. One mother could not see how such emotional conflict could be resolved except by leaving the Army.

> *I can't commit to the Army properly, say they send me to an operational Unit*
> *where they'd want me to deploy, I don't feel that I can give a hundred per cent*
> *to my job and that's what the Army is about because I'd rather stay with my*
> *little baby boy. Everything about life changed when I had my son, my*
> *priorities have changed. They always say the Army comes first, but no, he*
> *comes first in my eyes and that's why I am going to leave.*

<div align="right">Iv(2) SM:20</div>

One non-serving mother described this conflict as a "*tug of war*" in which the demands of the Army as an organisation pulled her husband one way, while he felt pulled in the opposite direction to meet the needs of their family. She gave a detailed description of the emotional turmoil suffered by her husband when he put his family first by declining to take part in a voluntary training exercise held during the school holidays, because he had planned to take annual leave with his family. His line manager had interpreted this as a deficient sense of loyalty to his Regiment. She felt 'the Army' was punishing the whole family as a result by relocating them earlier than planned. The following excerpt encapsulates the tension, conflict and distress this caused.

> *You've got this Regiment, this bigger hierarchy behind you that is sort of telling your husband what to do and what his priorities are supposed to be. The Army are not making it possible for soldiers to prioritize both their jobs and their family life. And that's affecting everything, which means we've now got to move, I've got to lose all my friends, my job I've just got. You can't separate life from his job,* (crying) *your whole life is uprooted you know and you've done nothing wrong really. And that's when you start thinking that it's almost a conspiracy to destroy families in the Army. They sent him on exercise the Friday before the kids were going on half term and then he came back when half term finished. So don't come and tell me that we, Army families, are a priority then, as I don't consider we are. It's fine if they are single, I think as soon as they put a priority on their family it just either ruins their career* [or] *ruins their family. We are all sharing him. The Army are pulling one way, and we are pulling the other way. He feels pulled both ways, with this tug of war between our family and his work.*

> Iv(2) NM:6

This incident highlighted to her that the Army was giving out mixed messages. On the one hand, the Government and the Army were using the media to emphasize the importance of supporting Army families, but in reality, there was little evidence of this commitment. In fact, this participant stated that she thought that the Army had a "*conspiracy to destroy"* families if they did not meet its requirements.

4.3 Impact of frequent relocation

Relocation appeared to have a major impact on the day-to-day lives of the whole family. Participants talked of moving home to any military location around the world, as the serving spouse moved jobs, termed 'posting.' Participants spoke of the *"rootlessness"* caused by moving home frequently and the ways that this affected the family. They articulated the sadness of leaving friends that they had

made during their current posting and the feelings of isolation and loneliness that resulted, "t*he loneliness as well of moving to new places especially from abroad*".

Moving home so frequently was a key feature that they perceived distinguished Army life from civilian life.

> *I think to explain to somebody who has had nothing to do with the Army that we move every two years, and you take all your furniture with you, yeah? and they just don't get it.*
>
> Iv(2) NM:1

4.3.1 Unpredictability of relocation

Most participants talked of moving every two to three years but some identified that in practice it was often far more frequent for some and for others less so. For example, one non-serving mother spoke of 11 house moves in 14 years of marriage while another spoke of spending ten consecutive years in one Army house in British Forces Germany. Some talked of being *"in limbo"* waiting for their husband to inform them when and where they would be moving next, particularly those mothers who husband was serving in a Corps.

> *Nothing is certain in Army life. My husband is due for posting at the moment. We are sitting, waiting, stuck in limbo until we get that posting order to know whether I need to find a different school for him* [son]*. Just nothing is certain. We never have certainty. We never know where we are, from one month to the next! We could get posted for five years but they could move you in 18 months.*
>
> Iv(3) NM:2

While most mothers spoke of a lack of choice of where they would be "*sent*" next, one serving mother highlighted that there was a chance to express a preference for the geographical location of their post provided that it met the Army's needs.

> *While there's not much choice, there is an element of choice. You do get to have a bit of a say but it depends on, you know, what job you are doing and what the Army wants, so whether you go there or not remains to be seen!*
>
> G(1) SM:20

One non-serving mother talked of discussing the options with her husband to ensure that his next post was nearby, to try to avoid the disruption of moving or losing the support network that they had built up over the past two years. However, this had backfired as although they had managed to stay in the same location even though her husband's post had changed, all of her children's friends had moved.

My husband changed his job in the summer, he brought the job list home, I said – 'Right, OK', I circled all the ones that meant we didn't have to move house because I didn't want the children to be disrupted, and I didn't want them to have to change schools and friends. Four out of the six of my son's best friends moved this summer. So we stayed static to give him stability and all his friends moved! So you can't win can you!

<div align="right">Iv(2) NM:5</div>

Some non-serving mothers, who had lived in many locations during their married life, talked of wanting to opt out of the relocation cycle by buying their own house in order to achieve some stability for themselves and their family. However, they realised that this was not practical and would result in even less time with their husband as it risked their husband being 'voluntarily unaccompanied', which would result in additional separation for the family if he had to take up a post a long commuting distance away.

I could buy my own house and live in it, but then I would never see him, as we would have to be voluntarily separated. I didn't get married to him and have three children with him to be on my own for most of the week while he works elsewhere and lives in an officers' mess somewhere Monday to Friday because he's been posted from where our house could be.

<div align="right">Iv(2) NM:1</div>

4.3.2 Re-establishing a support network

All the participants used the term "*starting all over again*'" in terms of setting up a new support network, finding schools and clubs for their children, registering with a dentist and doctor and getting to know their neighbours. They found this very frustrating, and the more times that they had moved, the more tedious the process became. The non-serving mothers spoke of the challenges of trying to find employment when they knew that they were likely to be moving again within two or three years.

Mothers spoke of moving home at short notice to houses they had never seen. One mother had to do so while her husband deployed. She used this as an example of how different her life was from her civilian friends who had lived in the same area all of their lives near to extended family and friends who could provide emotional and practical support. She viewed frequent mobility as "*hard work*".

I moved here, I'd never seen this house. It's not just the moving that makes us different, but everything that goes with it. It's not just physically putting your furniture in a van and unloading it at the other end. It's the fact that with the moving, those of us that work need to find new jobs, you need to find a doctor,

<div align="center">123</div>

a dentist, a football club and a Beaver's Pack for the children, you need to find the schools. Off we go again to do it all over again every two years. It's everything and you expect it all to be hard work and when it's not it's a really pleasant surprise.

Iv(2) NM:1

The degree to which they had to re-establish another network on posting seemed to depend on whether the soldier was posted en masse as part of a Regiment or as an individual serving with a Corps. Parents who were part of a Regiment talked of the camaraderie of being posted as a large cohesive Unit, when up to six hundred families would move together. Also, they did not seem to relocate every two to three years as mothers who husbands was serving with a Corps reported to have to do.

The whole Regiment packed up. We moved from Northern Ireland, where we'd been for some years, to Germany, where we set up again. All the friends I had were there, you moved 600 people up sticks and moved and basically like you pick that village up and move a few miles down the road, and everybody moves everything with them and we kept the same friends.

Iv(2) SF:23

Regimental families kept their network of Army friends throughout their postings and developed close bonds with each other as a result. They spoke of other families within the Regiment becoming like a surrogate family as they had moved around the world in a group as their children of the same age grew up together.

We're probably a little unusual, we are still quite old fashioned and we've still got a really, really good network of wives that stick together in the Regiment. We are self-sufficient really. The Regiment's your family and you do tend to start looking inwards instead of outwards for your help and your assistance. When they're [husbands] are away for six months, they are your family as the majority of us do not have family down here.

Iv(2) NM:12

Participants who were part of a Corps rather than a Regiment talked of a very different experience. These families had to leave their support network of friends behind them every two years and start all over again to establish a completely new support network. One mother whose husband was serving with a Corps reflected the views of others and expressed the emotional isolation caused by having to relocate every two to three years and live away from long-term friends.

> *Every two to three years, we move on, we make new friends, then we have to*
> *move on, make more new friends and so it goes on.*
>
> <div align="right">Iv(3) NM:25</div>

Another mother, who was serving, was able to speak of the stark differences from personnel experience as she was serving with a Corps herself but she was also an "*Army wife*" within her husband's Regiment. The former is nicknamed a "*trickle posting*" to reflect the constant flow of movement of Corps personnel and their families moving in and out of the garrison one by one.

> *One advantage that the sort of Infantry is more a sort of family in that they*
> *are all in it together as it were, you know, they do tend to be all located in one*
> *place. So there will be people you know from of old who are doing the same*
> *thing. Whereas people in Corps who get trickle posted, you know, move into a*
> *place who know no one and have no sort of support.*
>
> <div align="right">G(1) SM:20</div>

4.3.3 Welfare support

The parents based with a Regiment had the additional benefit of a well-established welfare system, co-ordinated by the Unit Welfare Officer who knew all of the families within a Regiment personally. One mother viewed the Unit Welfare Officer as a substitute for her husband in his absence. It was clear that the Army as an organisation emphasizes the importance of the role of the welfare department in supporting Army families. Participants talked of their deep respect for their Unit Welfare Officers.

Two non-serving mothers talked of the claustrophobia and lack of privacy of being part of such a close Army community, a *"gold fish bowl"* where everyone seemed to know everyone's business, stating that they had had it *"up to here with Army wives and the gossip and everything*". This lead to some wives detaching themselves from social activity for fear of being the target of community gossip, but doing this has led to feelings of isolation and loneliness.

If a Regiment deployed as a whole, it was entitled to a more extensive welfare package than when on training exercises or if individual sections (such as a battalion of infantry soldiers or a battery of artillery soldiers) deployed. Welfare support did not seem well established for the families of Corps personnel. Many mothers from Corps families commented that they had no idea who their Unit Welfare Officer was or how they would contact their welfare department if they needed too, admitting that they "*don't even know whether there's a welfare number that I could call".*

4.4 Impact of military enforced separation

The impact of military enforced separation, and particularly deployment, dominated the findings. In the current political climate, the parents assumed that deployment was an inevitable part of Army life. This created anxiety and fear for the mother left at home irrespective of whether she was serving or not. The participants viewed military enforced separation in terms of deployment, training exercises and courses in preparation for deployment. The process of separation raised a variety of different emotions in these mothers. All feared that their serving husband would be seriously or fatally injured during deployment. The pre-deployment phase was filled with emotional stress at the prospect of their husband's imminent departure and was disrupted by the unpredictability and intensity of pre-deployment training. The deployment phase was characterized by a jarring of changed routine and fear for the deployed spouse's safety, while the return from deployment and the post-deployment phase created both the joy and relief of reunion and the challenge of re-establishing relationships and re-negotiating routines. They spoke of a cycle of emotions very similar to those depicted in Figure 2.1.

All of the mothers had remained at home as the principal carer during the father's absence due to deployments. One serving mother had experienced leaving her child, although this was for a two-week training exercise only rather than a deployment of many months duration. She offered her interpretation of the differences in emotional attachment that fathers and mothers experienced with their children and concluded that serving mothers suffered a greater degree of emotional conflict than fathers did.

> *As a serving mother you do feel guilty leaving your child, since having her. I think it is different for mothers to go away instead of fathers emotionally. It's hard to describe, but there's a deeper maternal child bond than a father/child bond. I think emotionally it's much harder for the mother to leave the child than a father. I think men are able to switch their emotions off to the job at hand and get on with that without thinking so much about, or feeling guilty about all the "what ifs" and "why they are not with their child" and women are just more emotional about things.*

> Iv(2) SM:20

4.4.1 Types of separation

Mothers spoke of separation in terms of the type, such as whether due to training or deployment, and the impact that these different types of separation had upon them. The impact of separation in practical terms was the same regardless of the cause and made the mothers left at home feel like a "*married single parent*", being

married to a husband that was not physically there to support them. Many found this experience exasperating.

> *It is frustrating because we mums are not single parents, we do have our partners and they're not there, and I almost think that's worse because you are with your partner but they're not there. If you are single then you are single, that's it, you know. But having your partner there and then they go away and come back - It's like being single but not single. It's almost worse.*
>
> G(1) NM:13

The non-serving mothers felt that living through military enforced separation epitomised the negative side of being an Army parent. They became a lone parent for the duration of the separation without the luxury of the choice and stability of living near family and friends whom they perceived would provide practical and emotional support. All the participants referred to lone parents as 'single' parents, even though this term refers to marital status rather than if supported by a partner.

> *Single parents have always got long-term friends or long-term neighbours that they have known for many years or immediate family and within a very short distance that they could call upon.*
>
> Iv(3) NM:25

4.4.2 Frequency

Despite Harmony Guidelines stating that, soldiers should only be deployed for a total of 13 months every two and a half years (Ministry of Defence 2009), participants had evidence of deployments of six months duration occurring annually with only a break of four months in-between.

> *The operational commitments have greatly stepped up, so it is getting to the point where a lot of the families, where we were seeing one operational tour every two or three years, are now seeing an operational tour every year. We've got soldiers going next year and we've got a small Unit going to Afghanistan in February, another part of our Battalion takes their place half way in June/July time, and then another part of the Battalion goes away to Iraq in December. So you can guarantee that the solders that deployed in February will deploy in December as well, so they've probably got a four-month break between two six-month operational tours.*
>
> Iv(2) SF:24

Army mothers seemed very accepting of this.

> *My husband's tour-to-tour time, his shortest time has been eight months before he's gone on tour again. I think that's just the way it is nowadays, but it doesn't make things any easier.*
>
> G(1) NM:10

4.4.3 Notice of deployment

Participants talked of a great variety in the length of notice before deployment, which often depended on the role of the soldier and his job in the Army. Advance notice of deployment varied from a year to only a few hours if a soldier was on standby for deployment. The greater the notice period that parents had before a deployment, the greater the time they had to prepare the children so that their father's departure was less of a shock to them.

> *My brother had a 'phone call saying – 'You're going to Kenya on Friday'. He was shipped off to Kenya; he doesn't know whether he'll be there a week or two months. He gets 'phone calls at random. So I think it's harder for my sister-in- law and my nephew, because he* [brother] *has to pack his stuff and be gone within an hour and sometimes they don't know how long they are going to be away, whereas we tend to get a bit of notice in advance. I mean I've had 12 months' notice of my husband going to Afghan*[istan]. *You can prepare yourself, prepare the kids, you can tell them all about Daddy going away and they can be prepared. Whereas if you are packed and gone within an hour, for all you know, your children could be in bed, you wake up and Daddy's gone.*

> Iv(3) NM:25

There was a perception that giving short notice for deployments and training exercises was usually unnecessary and due to poor planning rather the intensity of military action occurring at the time. One mother was one of approximately 50 military GPs who had provided medical cover for previous Regimental exercises and deployments; she had received less than a month's notice for a three-month long training exercise abroad.

> *We are all subject to being taken away at a drop of the hat and you are always being trawled and dragged away to places even when you are not with your Unit. The Army just doesn't seem to be able to look ahead at exercises and deployments coming up and it's all last minute. I've just been abroad for an exercise; I had about a month's notice for that. In the meantime there have been about three or four other trawls come up for various doctors needed in Canada at the end of this month and then another one later in the year, so it's not much notice and we're talking about being away for three months, not just a couple of weeks.*

> G(1) SM:20

4.4.4 The pre-deployment phase

It was clear from the both serving and non-serving parents that while in theory the pre-deployment phase was a few months prior to deployment, in practice it was up

to a year in length. The months of preparation prior to deployment were particularly busy, as soldiers worked longer and more unpredictable hours to complete their training. Frequently, pre-deployment training was undertaken abroad for up to three months at a time. This increased the length of separation at a time when the families wanted to be together. With a high military commitment to Afghanistan, it was clear that most Regiments within the geographical boundaries of the study were involved in a continual cycle of preparing for deployment, on deployment or in their recovery phase from deployment before the cycle began again. It was evident that this increased the emotional vulnerability of these mothers when their child was unwell. The findings related to this are reported in Section 4.7.

The unpredictability of the actual date of departure required a considerable degree of flexibility and acceptance by the whole family; especially as pre-tour leave to spend quality time together as a family could be lost.

> *You've got to be extremely flexible; decisions are made at the last minute and that does reflect on soldiers and their families greatly to the point that this operation that we are starting next February, that was originally going to happen in March. So the month of February was due to be set aside for leave periods, time off, spending time with our families and that type of thing, only for us to find the operation has been brought forward a month, so we've lost the month of February, so we have lost leave, and time with our families.*
>
> IV(2) SF:24

Also, actual departure was never guaranteed until their serving parent had physically left.

> *And things change all the time. One minute they're going, the next minute they're not going, there's all the hassle leading up to before because they are away for two weeks, back for three days. It's a nightmare.*
>
> G(1) NM:6

The constant and unpredictable comings and goings meant that establishing a routine was difficult.

> *Because when the husbands are not here you get into such a good routine and they come back and it's just completely messed up again, and you sort of get that help there, and then it's gone again and it's sort of mixes you up all the time. I find it really hard when he does go away, because I've had all that help there, and then he's gone and I just find it so difficult to get back into a good routine again.*
>
> G(1) NM:14

4.4.5 Separation phase

Change of routine

While departure and the stress of farewells could be traumatic emotionally, it permitted the upheaval and disruption of the pre-deployment phase to be replaced by the ability to establish new routines that would not be disrupted by the inevitable change of plans caused by the unpredictable comings and goings of the father preparing for deployment. One father spoke with admiration how his wife coped, as if her status as an "*Army wife*" contributed to this.

> *My wife will find it easier in a sense when I go off to Afghanistan because she doesn't have to worry about me constantly bouncing back here and wrecking everything. She can get into a proper routine when I go away, you've got six months away and you've got two weeks holiday planned in between. That's fixed in stone, so it's easier for my wife. She takes on everything that I do within the household while I'm away, she's a true Army wife, I'm in admiration of her!*
>
> Iv(2) SF:23

It was likely that the mother left at home would have an estimation of the length of separation, when any mid-tour leave was scheduled and when the deployment should end.

> *I'll know what I'm doing. He'll tell me when his R and R is* (ten days home rest and recuperation leave in the middle of a six month operational deployment) *and I'll be able to factor that in for my three months. So I will be able to plan things whereas at the moment he's not quite sure where he is, or what he's doing for the next six months while he's preparing to go, so therefore it throws me a bit because I can't plan anything.*
>
> Iv(2) SM:19

Following the husband's departure, the necessity to establish a new routine made the husband's absence all the more apparent.

> *So it's hard because you start to rely on someone and then you lose them. For the first few weeks I find it really hard. But then obviously you get back into that good routine and everything.*
>
> G(1) NM:14

The mothers interviewed not only tried to establish a routine during times of deployment, but also altered the normal routine that they had when their husband was at home. For example, one went to bed very early to pass the time.

You adapt to your surroundings if your husband's not coming home every night. You know people ring me at 8 o'clock and I'm in bed! (Giggles) - 'What are you ringing me this late for?' Get a life! So you know, when [husband] *is here I don't go to bed at 8 o'clock and watch Eastenders in bed, have a cup of tea. (Giggles) But when you are on your own, you do!*

<div align="right">Iv(2) NM:1</div>

Another mother found the evenings were much busier than when her husband was at home. This was because her evenings were filled with domestic chores that she could no longer do while her children were awake as her husband was not at home to help her with the childcare.

If I sit down that's me forcing myself to sit down and say just half an hour to watch Coronation Street or something. Goodness there is always ironing, or washing and the dishes or things to plan, what you are doing the next day or getting the bags ready for playgroup.

<div align="right">Iv(2) NM:2</div>

Impact on leisure time

Mothers explained how their husband's absence reduced the quality of their leisure time. Their felt their husband's absence much more acutely at weekends, which made them reflect upon how different life was without him. During his absence weekends had to be endured with dread, whereas they would have anticipated them with pleasure had their husband been at home. Mothers spoke of feeling more lonely and isolated because of a lack of organised children's activities at weekends that normally got them out of the house during the week.

When you're on your own, weekends are awful, and everyone else is holding hands, skipping up and down the road with their husbands, we are all indoors killing our children! (Laughs)

<div align="right">Iv(2) NM:7</div>

On the other hand, they felt comfortable calling friends who were also undergoing separation like them, as they knew that they would not be disturbing their friends' united family time at weekends.

And because two of them their husbands are also on tour from the same Regiment as my husband that was reassuring for me because I thought 'well if I 'phone I am not disturbing her'. Whereas I know my other friend's husband was there so she would have been the last person I would 'phone, because I wouldn't want to disturb her family time with her husband at the weekend.

<div align="right">Iv(2) NM:6</div>

Several mothers concluded that the impact of separation was made worse as things always seemed to go wrong when their husband was away.

> *It just seems to be always something goes wrong. It would still go wrong if they were here, but it's not such a big issue when they're here. Everything seem to go wrong as soon as he's not here!*
>
> Iv(3) NM:28

The Unit Welfare Officer played a crucial role in maintaining morale by organising social functions to keep Regimental families occupied during deployments. Participants expressed their gratitude for all the welfare functions organised for the families during times of deployment, such as picnics, coffee mornings and free fun days out for the mothers and children from the Regiment who were left at home. Such events appeared to be of great benefit to the Army parents in terms of keeping them occupied, as it distracted them from their fear for their husband's safety. Also, it made them feel valued and confirmed to them that their husband's Regiment cared about them as individuals and acknowledged the pressure that they were under during times of deployment.

> *The Welfare Officer was brilliant during the last deployment and organised lots of family days - barbecues and coffee mornings to keep us families occupied. I had to force myself out of the house initially with a new-born baby, but it was worth it as otherwise I would have been really lonely.*
>
> G(1) SM:20

These parents acknowledged the importance of such activities during times of deployment when according to one participant, the work force of the welfare department and the number of cars available to transport families increased for wives who had no access to transport in their husband's absence. However, welfare resources focused on times of deployment and did not include training exercises despite the practical impact of separation being similar upon the family left at home. One participant spoke of her Unit Welfare Officer within the Regiment as a surrogate husband during times of separation as he was prepared to do emergency repairs around the house that her husband would normally carry out if he were at home.

> *When my husband deploys – everybody else that's connected with the Army from the Regiment such as the Unit Welfare Officer becomes my husband for that minute. So if* [name of daughter]'s *ill, and I need to speak to a doctor or a nurse, they* [the Army] *take over his* [husband] *role. He* [Unit Welfare Officer] *provides that steadying role for that minute. If I need to talk to the Welfare Officer, he becomes my husband for that minute.*   G(1) NM:8

Potential emotional upheaval

Mothers discussed expressing their emotional vulnerability in different ways; one serving mother described spontaneously bursting into tears in front of strangers, another mother talked of minor irritations becoming a crisis in her husbands' absence. Little things mounted up which would not have distressed her as much if her husband had been at home. Mothers missed their husband's practical help and emotional support.

> *For me I think the main difference when my husband is away is just a lot of the little things that build up and I just find it more difficult. If somebody said "what's wrong?" It's nothing really, but when you are tired, it's horrendous.*
>
> G(1) NM:9

These mothers spoke of the "*rawness*" of their emotions when their husband was away; of a feeling of panic at the slightest thing and of being "*much more emotional and ratty*" than they were when their husband was at home. One mother even talked of reverting to childhood behaviour and suddenly becoming afraid of the dark when she was alone in the house with her children at night. Childhood illnesses seemed much more of a threat, resulting in a greater degree of panic if their child was unwell.

Mothers expressed the need to protect their children from their emotions; they strived to keep to a daily routine in order to maintain normality for their children.

> *You have to cope. You've got that added pressure and trying not to let it show for the children.*
>
> G(1) NM:10

Mother's spoke of trying to maintain stability for their children by taking on additional roles in their husband's absence. This was to mitigate and protect their children from the void that their father's absence created.

> *You're everything aren't you? During the day and the evening when they're away, you're Mum and Dad, grandparents, aunts, uncles, the whole lot.*
>
> G(1) NM:11

This could be tough physically and emotionally for the mother who tried to take on some of the father's role as well.

> *The other night my three year-old was jumping on me and the baby was rolling on my legs and I was like – 'I am not Daddy! I'm not strong enough for this'. But then I thought - 'I've got to do it because that's what Daddy*

does'. So you feel you have to be a bit of a Dad as well as a Mum I think, especially with two boys, because my boys like football and rugby and he [elder son] *likes to be out on his bike, and he loves cars. So I do feel quite a lot of pressure and things, this is my Daddy role on top of my Mummy role now.*

<div align="right">Iv(2) NM:2</div>

Mothers universally used the term *"burden"* when they were giving their views about how military enforced separation affected their lives. They saw*" burden"* to mean having to have sole responsibility for all of the childcare and day-to-day management of the house, making all the decisions as well as dealing with any crises that occurred in their husband's absence. For one mother, the additional pressures created by her husband's absence were directly proportional to the impact of how hard it was without him, not being able to share "*half*" of the pressure in his absence made it "*twice as hard"*.

> *It's harder when they're* [husbands] *not here, the whole thing's on your shoulders, and that's it. You can't share that burden with anybody. You're on your own!* (Laughs)*, you get on with it, 'cause you ain't got a choice. Even though they might not be able to do any more about it than you can, it's still half the issue when they're here. It's kind of twice as hard really when they're not here, 'cause you've got nobody to half it, if you see what I mean.*

<div align="right">Iv(3) NM:26</div>

Despite this need to be strong for their children, there were times when carrying the "*burden"* got too much. One mother gave a vivid story of when her 3-year-old son required emergency admission to hospital for a chest infection during husband's absence; having to find a parking meter that worked at the hospital was the final straw.

> *Going to the hospital my 3 year old is sorted but there is still nobody saying to me – 'Don't worry, it will be OK'. If my husband was here, he would be driving, he could say – 'Don't worry', and it would be just me that would be nervous. My son was absolutely screaming because he couldn't breathe properly and I was just crying my eyes out, thinking - 'oh my goodness! This is just too much for me'. He was sick all over me and all over himself and then the pay meter wouldn't work so I had to walk to the other car park, find a meter there, and come back. It's just too much.*

<div align="right">Iv(2) NM:2</div>

The loss of the husband's practical and emotional support meant fatigue could become a major feature, which also increased their emotional vulnerability.

> *Things tend to be a lot easier if my husband's around. Just because I feel like I've got that support and that back up that he provides, so you are not quite so exhausted, so you are not quite so run down. If I'm on my own, it's a lot harder especially if she's* [daughter] *not slept – I wouldn't be functioning or thinking straight probably.*

> Iv(2) SM:31

All of the mothers, irrespective of whether serving or not, gave a real sense of what it was like to live with the constant fear during deployment of not knowing whether they would see their husband again. They spoke of "*waiting 'for the call not to come"* to inform them that their husband had been killed or seriously injured. This created constant anxiety every time anyone knocked on the door or the telephone rang.

> *Because you always think - 'is it that next 'phone call?' But if someone comes to your door, you know, you are always thinking 'Is that person going to tell me that something's happened' you know?* (starts crying).

> Iv(3) NM:29

A clear demonstration of the power of these emotions could be seen as all of the mothers became tearful when talking about the fear they had felt for their husband's safety when he was he deployed, even though for some he had deployed and returned over a year before their interview with me took place. Fear of deployment and for their husband's safety was always on their minds, as even if their partners were at home they feared that the next deployment that would "*inevitably come along*".

During times of separation, a combination of the many emotions experienced by the mothers left at home such as worry, fear, isolation and loneliness, led to some mothers feeling overwhelmed at times. The level of fear depended on the degree of danger each mother perceived her husband to be in as well as the ease with which she could communicate with him to know whether or not he was safe. None of the 24 participants who took part in Phases One and Two were directly affected by deployment, unlike the participants who took part in Phase Three of the study. The degree of fear expressed by the participants in their interviews with me increased in intensity from Phase Two of the fieldwork (undertaken in 2008) to Phase Three (undertaken in 2010). This reflected both the increase in the number of deaths and serious injuries suffered by deployed troops in Afghanistan and the number of

deployments in which the friends and family of the participants were directly involved. The stress and anxiety that this caused was reflected in the participants' stories who spoke of the reality of living through the period of their husband's deployment:

> It's stressful 'cause you hear what's on the news, and everything like that. Just worrying all the time; you never seem to have a day where you don't worry, so it's just stressful and worrying, you know, and you don't know when you are going to get a 'phone call, so you're like - 'Oooh I'm going to get a 'phone call tonight', you know, so it's just lonely and scary (starts crying).
>
> <div align="right">Iv(3) NM:30</div>

One mother spoke of going through an imaginary scenario of her husband's death as a protection mechanism to prepare herself mentally for the worst scenario so as not to tempt fate. She told me that she had done this even more during her present separation as she was close to the end of her husband's final deployment because he was due to complete his Army career a few months later.

> And I just accelerate my brain a bit and think 'God, this is his last one, he's out at the end of the year, it's his last one and he's done 23 years and wouldn't it just be the headline you know 'he's done 23 years and blah, blah, blah'. Then I go into all sorts of imaginary stuff, I have to explain to my three year old and he's going – 'What am I going to do?' And I see these pictures of him at ten with Daddy not there and I'm taking him to car shows and you know I just do that a lot. It may be a bit tougher because it's our last step if you know what I mean. Maybe because as I say, it's because he's out [of the Army] at the end of the year.
>
> <div align="right">Iv(2) NM:2</div>

Despite the fear and acknowledgment of the risk of death, the words 'dead' or 'killed' did not appear in any of the data. Participants did not seem to be able to use these words and referred to such fears using expressions such as "*if he doesn't come back*" or "*the last time I'd see him*" instead.

> When he first went away, it was his first tour I'd had to deal with, so I didn't know whether he would walk out the door and it's the last time I'd see him. You think about stupid things like that.
>
> <div align="right">Iv(3) NM:25</div>

The degree of danger that they presumed that their husband was exposed to affected their level of fear. While they assumed that patrolling the streets of Iraq or

Afghanistan was the most dangerous role during deployment, most mothers appreciated that the camp where soldiers were living was no longer a haven of safety from Improvised Explosive Devices and suicide bombers as it had been in the past.

> *My husband was in quite considerable danger, especially as his Battery* (a group of artillery soldiers) *was going out as an Infantry role, as opposed to Artillery where you sit back and fire stuff from a distance, which I am reasonably happy with. He was in charge of an area where he had to go out, travel to the area and patrol the streets. So I knew that was much more risky than sitting back in the camp. The camp was having a lot of incoming fire at the time too.*

> Iv(2) SM:20

Many mothers discussed the rituals that they maintained to protect themselves, such as "*trying to avoid the news*" during times of deployment. They took a fatalistic approach that "*no news was good news"* and that they would hear through the official military channels if their husband had been killed or injured. Mothers did not find the sensationalism or media exposure helpful during a deployment.

> *I try to blank the news. If something that's happened that I need to hear about, I will be told. And there's no point in worrying and kind of getting yourself in a state unnecessarily. I watch the local news, which I suppose is quite nice, it's like burying your head in the sand. And as well, I don't want the boys to see it, to see soldiers have been killed. Especially my eldest, he's six so he would really pick up on that, and if there's tanks on the television. 'cause his Daddy's in the Tank Regiment – 'Is that Daddy? Is Daddy in that?' and you think - 'I don't want them to hear people'. So I kind of shield them.*

> Iv(2) NM:1

On the other hand, they did "*sneak information*" as they wanted to have some awareness of the political situation so that they would know if there was a communication embargo because of an incident. Such an incident would prevent them receiving telephone calls over the following few days. They tried to avoid listening to "*school bus stop rumours,*" but this was difficult as normally all of their friends' husbands deployed together so news of one husband affected them all. Two wives spoke of their "*guilty sense of relief"* when they heard the next of kin have been informed about an incident because *"it's not me,"* and of feeling that they had had "*another lucky escape*" from the suffering of bereavement that they dreaded.

One spoke of a need for reassurance from her husband prior to his deployment that he would not put himself under unnecessary danger and thereby increase his chances of coming home at the end of his tour of deployment.

Mothers felt that training exercises caused them as much anxiety as deployments as they mimicked deployed scenarios as closely as possible and used live ammunition. One spoke of knowing a soldier who had been killed on exercise in the past, but that such a tragedy had not summoned the same media or political interest as deaths during deployments to Afghanistan or Iraq. As a result his death had not been recognised outside military circles and so he had not been posthumously heralded a hero.

> *I got quite upset before he* [serving husband] went *away. He said – 'What's wrong? I'm just going on exercise in Canada!', 'What if you don't come back?' And he said 'What do you mean if I don't-' I said ' 'You told me years ago that lots of people die on exercise but it's never really an issue, it's never brought to light you know, it's never on the news or anything like that because it's just an exercise'. I suddenly remembered two friends of my health visitor- they had recently died on an exercise, and she'd just said, - 'the thing is they died unknown', not a hero, nothing, they just died because they were just on an exercise and not in Iraq or wherever.*

> Iv(2) NM:2

Difficulty in communication

There was a remarkable acceptance by these mothers that communication with their deployed husband would be curtailed, a situation which they were unused to in a technological age of instant communication.

> *It was quite difficult because in the last few years with mobiles and everything, you've had this contact that is unlimited haven't you? You can ring and get hold of each other whenever you wanted, so I do feel this has gone back to old school. Because I've been with my husband since he joined up since he was 16 when it was just letters and he was just writing and no 'phone calls, and we've progressed so much in technology about communication.*

> Iv(2) NM:6

Communication during training exercises was sometimes even more difficult than during deployment because welfare satellite telephone cards and free post were only available during deployments and not training exercises.

> *On deployment you get your minutes of free 'phone calls and you get free post and things like that, whereas on exercise there is no free post or bluey's,*

there's not much welfare for either the deployed or the non-deployed, it's just accepted as part of the job.

<div align="right">Iv(2) SM:20</div>

The telephone became a great focus of fear, joy and anxiety during times of separation. Ironically, the lower the risk to the husband in the separation period, the greater the contact they had with their wives, although there were occasions when soldiers were on live firing training exercises in Canada and underwent a communication curfew which prevented any form of communication to home for up to three weeks.

He's just gone out to into the prairie, so there's not any contact or 'phone calls, so I find that quite a lot of strain.

<div align="right">Iv(2) NM:6</div>

Communication via telephone during deployments was very spasmodic and was controlled by the soldier away deployed or on a training exercise; no personal telephone communication could originate from the UK. As a result, mothers spoke of the comfort they got from 'e – [electronic] blueys', aerogrammes that they could send electronically with photographs attached free of charge (see Army terminology and definitions). This was particularly important for one participant whose husband had deployed two weeks after their child's birth, which meant that she could keep him in touch with their child's development during their many months of separation.

Any telephone contact with their husbands was of great importance. Most spoke of the telephone as their preferred method of communication because of the ability of being able to talk to one another. Answerphone machines became crucial as a record of their husband's voice and of any missed calls from their husband. Participants talked of keeping all the messages until their husband had returned safely. They spoke of the comfort of listening to messages repeatedly.

I've kept all his messages on the answer machine, because I just like hearing his voice every now and again. This morning I got in from shopping and I automatically just go through them all then. I've done that wherever he is until he's come back home, I've kept all the messages on there.

<div align="right">Iv(2) NM:2</div>

They emphasized the importance of provisionally arranging a time with their husbands for him to call, but also of their distress if they missed the call after confusion with the time difference or if their husband had not been able to call at

the designated time. Mothers discussed altering their daily routine with their children in order to ensure that they were home just in case their husband should call, even though they knew that this was unlikely. This added stress to daily activities, with one mother speaking of the panic that she felt when waiting in shopping queues in case this delayed her return home and she missed a call from her husband as a result.

The different time zones of deployments or foreign training exercises complicate communication via telephone. Participants also highlighted problems with communication due to insufficient and unreliable systems, with a voice delay on the telephone making even the shortest conversation difficult.

> *'Cause they're seven hours behind in Canada. You still can't have a proper conversation 'cause you get a delay on the 'phone, and then you end up repeating yourself. I can tell him what's happened, but I can't tell him as if he was sat there. He's got a 'phone card that's only got so many minutes of it, and you've got to get everything out in such a short space, so you can't have a normal conversation.*
>
> Iv(3) NM:26

However, a maximum of 30 minutes allocated telephone time a week was far too short for these mothers to accept. Such a short time did not give deployed personnel sufficient time to talk to all of their family members. Also receiving an equivalent telephone allowance to a prisoner made them feel devalued, reducing their potentially low morale further.

> *They only get a 30 minute 'phone call a week, we could do with a bit more contact from them, especially when you've got children. By the time you have spoken to your husband on the 'phone, there's not really that much time for the children to speak, they need to talk as well; they need to hear Daddy's voice. You get more time in prison on the 'phone than what they do in Afghanistan and that certainly gets you down.*
>
> Iv(3) NM:25

They highlighted that sometimes it was even difficult for their husbands to use the allotted telephone cards because of the long queues at the satellite telephones. One mother dealt with the challenges of communication by accepting that she would not hear from her deployed husband.

> *When he goes, I don't hear from him. He's been away when* [son] *was very little, he went away to Belize for about eight weeks, and I think I heard from him about two or three times.*   Iv(2) SM:19

The challenge of communication via the telephone meant that one mother had reverted to communicating via letter; she had found that recording the day's events to her husband was very therapeutic, particularly if it had been a difficult day because her child had been unwell.

> *Because I couldn't talk to him and I couldn't e-mail him because I kept getting timed out, I got into bed, with a pen and paper and I just wrote and wrote and wrote and wrote and wrote and wrote and all about the day and everything.*
>
> Iv(2) NM:2

Participants discussed the emotional benefits of the 'Storybook soldiers' scheme. This was designed to enable deployed personnel to record a story for their children to listen to while they were away (Defence News 2007, Eadie 2010). One mother spoke of the comfort it gave her to hear her husband's voice telling her three-year-old son a story, while her son thought that he was having a conversation with his father and that he was speaking to him from within the compact disc player.

> *Emotionally I think it's helped him* [son], *you get to hear Daddy's voice and he talks back to him because my husband says – 'Hello, it's Daddy here!' And he says – 'Hello Daddy!' I am sure he really feels he's having a conversation with him, so for him I think it's nice that he feels that his Dad's here.*
>
> Iv(2) NM:2

Mothers were aware that there would be a communication blackout if there was an incident to allow time for the next of kin to be informed. If they did catch news of an incident, it was a relief to know that the next of kin had been informed and that they could assume that as they had not been contacted, their husband had not been killed or seriously injured.

> *If I heard on the news that somebody had been killed, then I knew I wouldn't hear from him for days because they have like a communications blackout procedure for e-mail and 'phone from the moment that an incident happens until the next of kin are informed. By the time it hits the news pretty much you know the next of kin have been informed, because the systems are pretty quick, and it's quite nice in that respect!* (Laughs) *And also they say on the news "the next of kin have been informed" so families at home are not left wondering is it their relative or not.*   Iv(2) SM:20

4.4.6 The post-deployment phase

Mothers gave detailed accounts of the enormous relief that they felt when they knew their husband had returned safely, although they identified that the period of readjustment and reintegration could be a considerable source of stress. Once the euphoria of knowing that their husband was safe had passed, experiencing a

disruption to their routine again created friction and conflicting emotions in them. Simple things such as the husband's apparent untidiness were a major source of frustration for many of the mothers who spoke of the challenges of trying to re-establish a new equilibrium. Roles and routines had to be re-negotiated for all members of the family.

> *When they come home, it's fantastic but it's frustrating when they come back. My husband in particular is messy, so I've got this nice tidy house, he comes in and he dumps all his stuff and six months later it's still sitting there! And it's just that they are there, so you've got to think about when they are coming back in the door, and what they are doing. Ever since he's* [serving husband] *been back he's been in work, then he's been on leave, then he's been away, then he's been in work, then he's been on leave, then he's been away, and I just don't know what's happening from week to week. Whereas if he's away and if he's deployed I know he's away, he's gone for six months and we can relax!* (Laughs).
>
> G(1) NM:17

Mothers expressed that the period of readjustment during which they had to re-establish the dynamics of the family and renegotiate the roles that had altered because of the father's absence could be quite demanding emotionally. Disciplining the children became a cause of disagreement between couples and a source of tension as the family dynamics had had to change to include the father once again. One mother spoke of her husband's loss of tolerance of his children's behaviour, which she felt he used as a way to assert his authority once again.

> *I actually find it hard when he* [husband] *comes home from deployment with disciplining with the kids, because I don't like him shouting at them, telling the kids off, because I think - 'Well you know, you go away so much, just let me be the baddie. Let me be the bad parent. You be good cop, I be bad cop'. And you know we end up arguing over that 'cause he's like - 'No, the kids should know that I'm there to discipline them as well'. But I just feel so bad because I think 'no they don't see you and you come home and you are yelling and screaming at them.- 'Let me do that and you be nice dad.'*
>
> G(1) NM:9

The expectation of having some quality family time during post-operational tour leave was not always realised.

> *I mean this last four weeks they've been out away from camp. He's done several days' work, even though he's been on post tour leave! And that I find*

quite frustrating, because I am expecting him to be on leave with us, but he's not.

<div align="right">

G(1) NM:11

</div>

Small children (under three years old) seemed particularly wary of their returning father.

I'm the one that goes away, so when I come back, my daughter's scared of me. The first time I came back, she [daughter] *didn't want to know me, she was scared of me, like she was with strangers and that.*

<div align="right">

G(1) SF:23

</div>

They had to build up trust and familiarisation with their child again.

Little [son] *takes a while when Daddy first comes back; he's a bit wary of him. He knows who he is, he tends to come around me a lot. But then once he's used to Daddy he will be over there, because he knows he can get anything he wants because my husband spoils him a bit, because he doesn't see him and he just gives in to him.*

<div align="right">

Iv(2) SM:19

</div>

Section Two - The decision to consult

The following section discusses the findings related to the decisions that these mothers made when their child was unwell. Some of these findings have much in common with evidence in the civilian literature, while others are specifically caused by the challenges that Army life presents to parents.

4.5 Mother as protector

Mothers used their own knowledge of their child's normal behaviour to assess the child's level of discomfort. Common expressions used by most of the participants included *"Not right"* or *"Wasn't her or himself"*. They assessed their child's degree of distress as a measure to help them to decide if they felt confident to treat the illness or injury themselves or if they needed to access a health professional.

> *She didn't seem herself, she's normally really cheerful, really happy, and she was just really hot, really sleepy and she just wanted to cry and cling, and she wouldn't stop crying, which I found really unusual. She was just not herself and that upset me initially, so I picked her up, got her in the car and I just thought - 'Right, I know that the medical centre will see her'.*
>
> Iv(3) SM:31

They emphasized that *"you know your own child"* and that no one knew their child better than they did. As a result, they were less concerned if the child was not distressed despite not being *"himself"*.

> *He wasn't himself but I looked at him and thought - 'He's happy in himself, he's drinking, he's eating.' So I didn't think there was anything seriously wrong with him. Although he wasn't himself, he was still his happy chappie self, he was exactly the same as normal apart from the fact that he was throwing up and had a terrible bum and his nose was running.*
>
> Iv(2) SM:19

It was clear from the way the participants spoke of their role as mothers, that they took their role as gatekeeper for their children and responsibility for their children's welfare very seriously. Clearly, parents wanted to do the best for their children, to prevent them from the harm of illness or injury and were fiercely protective of them. They envisaged protection not only in terms of safeguarding their children from the unpredictable disruption caused by Army life that was discussed in the previous section, but also in terms of being an advocate for their child in which easing their child's distress was a priority.

> *It's your child, when they're unwell it overrides any other thought or anything; you need to get them sorted.*   Iv(2) SM:18

Having a diagnosis was important to help them understand how serious their child's illness or injury was. Parents discussed continually monitoring and assessing their child's behaviour and comparing it to when the child was well. Mothers described checking physical signs frequently such as whether their child felt hot to the touch or had diarrhoea.

4.5.1 Making sense of the illness or injury

Mothers tried to make sense of the illness but acknowledged that there were certain symptoms that caused them to feel out of control - a "*tipping point*"- such as a high temperature.

> *I'm always worried that if her temperature is too high for too long that's bad, that's what's my greatest indicator that something's wrong for me is, the easiest indicator. Sometimes she's grizzly but hasn't had a temperature, and it's like I am not quite so concerned, I haven't really been that alarmed. It's the temperature that's the tipping point when you can't control it.*

<div align="right">Iv(3) SM:31</div>

Their need to be in control of the symptoms influenced the urgency with which they sought medical aid.

> *It just like – it just came on all of a sudden and she just started breathing really rapid, and struggling to breathe as well. If you can't control – you can't contain them or stop it, what else do you do? We took her straight down to the out-of-hours doctor then.*

<div align="right">Iv(2) NM:2</div>

Apart from assessment of their child's behaviour and degree of discomfort, mothers used external signs and symptoms to assess the condition of their child; the sighting of blood was a major cause of concern and panic.

> *He'd* [son] *had just come in, and he was whingeing, and he just went* [makes vomiting noise] *and there was blood all over the kitchen floor! I was like - 'Oh my G*d, where did that come from?' I panicked then. I'm not very good with blood anyway, and I panicked, and I was like – 'Open your mouth!' And he opened his mouth and I saw a big hole in the back of it, and I said – 'Right, hospital, now, 'cause that needs sorting now!'*

<div align="right">Iv(3) NM:26</div>

Previous experience of an illness also influenced how quickly mothers sought treatment. If delaying seeking treatment for a particular illness had increased their child's suffering in the past, they were more likely to seek help more quickly in the future.

> *My daughter suffers massively with really bad tonsillitis and you know her*
> *tonsils are scarred to death you know because she suffers really really badly*
> *with it. If I wait until the surgery is open on the Monday to be able to get an*
> *antibiotic, then she's gone downhill really, really fast. It takes quite a long*
> *time to bring her back, so now I get her to the doctor as soon as I can as I*
> *know well within 24-hours of taking antibiotics, she's generally feeling a lot*
> *happier and better.*

<div align="right">G(1) NM:17</div>

A mother's confidence in dealing with future illnesses diminished if a previous episode had proved to be more serious than she had anticipated.

> *I rang the out-of-hours, I didn't think it was serious, and within two minutes*
> *we had an ambulance, paramedic and went down to hospital. The lady on the*
> *call alerted the nurse who said – 'Ooooh is that him* [baby son] *I can hear?'*
> *And I said – 'Yeah!' And she was like – 'Right I'll put you through to 999.'*
> *Because obviously then I didn't even think to call them, he'd* [son] *already*
> *been to the out-of-hours and they'd given him antibiotics and they obviously*
> *hadn't worked so he needed something else. But I didn't call 999 as I didn't*
> *think he needed an ambulance, I was a bad mother. It's like -'Oh dear, bad*
> *mother!' I only thought he was a bit wheezy he's fine. I'll like be a lot more*
> *cautious next time and act quicker.*

<div align="right">G(1) NM:13</div>

"*Bad mother*" was an expressions used by several mothers when recalling incidences when they felt that they had failed to act as protector for their child because they had not interpreted their child's symptoms as serious as they were.

> *We* [parents] *weren't sure that she'd broken her arm, because it wasn't*
> *swollen enough and so we left it 'cause I am a bad mother! It wasn't swollen*
> *at all. After two days we took her to the doctors and she'd broken her arm in*
> *four places! What a bad mother!*

<div align="right">G(1) NM:8</div>

Most mothers did understand the difference between viral and bacterial infection and assumed that if their child did not improve following treatment with antibiotics that they might have a viral infection, which just needed to take its course. However, there was an assumption that viral infections were less serious as they did not need to be treated with antibiotics, and that any illness causing great distress to their child could not be a viral infection.

> *It wasn't just a viral infection, she was struggling to breathe, and with viral infections, you don't struggle to breathe.*
>
> Iv(3) NM:25

Mothers seemed to assume that once treated with antibiotics there was little more that could be done and receiving a prescription of antibiotics justified their attendance at the clinic. Some mothers identified that some doctors were reluctant to prescribe antibiotics when their child's illness had warranted them being prescribed. One mother gave a detailed description of her child being unwell for three months before a doctor finally agreed to prescribe antibiotics. The unnecessary suffering for her child had caused her considerable distress:

> *The out-of-hours doctor offered me antibiotics for her* [baby daughter], *which is what nobody else had offered me in the whole three months that she's had this swinging a fever for three months. She had the antibiotics and in 72 hours of her having the antibiotics, she was like a different child! The antibiotics really kicked in, I was absolutely devastated! I was so upset about it all, because she obviously needed the antibiotics, and she'd probably needed them since October. I must have had her at the doctors with the same complaint about five times. And I was so, so upset about it, because I just felt completely let down by every doctor that I'd seen prior to seeing this doctor who gave her the antibiotics.*
>
> Iv(3) NM:29

They found it very frustrating that antibiotics were not dispensed by the out-of-hours clinic as this delayed their child starting their treatment straight away. Parents had to find a pharmacy in the middle of the night or wait until the next morning.

> *If you do get lucky enough to see the doctor and they say 'yeah, you need antibiotics', you then think – 'Oh great where do I go now?' It's 2 o'clock in the morning, where do I go and get some antibiotics from?'*
>
> G(1) NM:12

4.5.2 Fear of rapid deterioration and serious illness

Mothers perceived that health professionals would give children greater priority than adults and that no doctor would refuse to see a child straight away.

> *She was probably only just over a year. She just sounded awful; you could hear her little wheeze on her chest and I just thought 'it's better that I get her checked out as otherwise I'm just going to be, you know, really worried'. So I took her to the out-of-hours clinic and they fitted me in straight away which was great.*
>
> Iv(3) SM:31

They assumed that this was because children could deteriorate uncontrollably and quickly.

> *It came on really suddenly, I realised she was suddenly really struggling to catch her breath and stuff, I thought she needed to see a doctor straight away. It was pretty scary, her chest was really, really wheezy and I just started panicking really because that's never happened before. I just thought 'she needs to see a doctor now', so I took her down to the out-of-hours* [clinic] *and they saw her straight away.*
>
> <div align="right">Iv(3) NM:25</div>

The thought of missing a serious illness in their child terrified them. Meningitis evoked the greatest fear, not only because it could kill their child but because of its rapid onset. Stories of other children being "*dead in the morning*" increased their anxiety and fear, particularly as it was more difficult to be rational about matters related to one's own child.

> *You're terrified of missing anything. We've had young girls in the Regiment 'we'll hang on till morning' and by that morning that child was dead because he had Meningococcal septicaemia. You know you want to be reassured that what's happening is normal and every mother is fearful, anything that can happen really quickly to their children. We're all sort of reasonable when it comes to other people's children but you know we do tend to be over anxious with our own.*
>
> <div align="right">G(1) NM:17</div>

They seemed aware that a non-blanching meningococcal rash is a symptom of meningitis; as a result, rashes seemed to be a major concern. Many knew about the 'glass test' but did not know how to do it properly. This meant that performing the test caused great anxiety as any positive result confirmed their greater fears and created unnecessary panic, even though in the majority of cases the positive results were false. Sometimes medical knowledge of such symptoms caused unnecessary panic and fear that they might be missing a serious diagnosis, when in fact their child's symptoms were quite harmless as the following excerpt with the participant who was a GP exemplifies:

> *Suddenly she* [baby] *was covered in a most horrible looking rash. So we were sat in the kitchen and I thought - 'Right, I'll get a glass out, do a glass test.' And to my horror on her arm, they weren't going or blanching and I sort of thought – 'Oh no! It can't be anything like that', so I was just trying to go through all these thought processes logically. I can sort of see now why she*

had these non-blotching spots, because we went swimming, she had armbands on and I wonder (laughs) if that's what caused a few non-blanching spots on her arm! But all sorts of things were running through my mind. 'Oh my G*d, am I just being really blasé and missing something which is quite serious?'

<div align="right">Iv(2) SM:20</div>

Parents described their panic if such a scenario occurred with more than one symptom of meningitis, as one father explains:

If he's got a temperature, I can't get it down – and then all of a sudden he's getting blotchy skin, you think about that leaflet - 'Meningitis kills.' And then - 'That's two out of five' then three out of five and think - 'Oh hang on! I need help now', the exaggeration comes out, the assumptions come out - 'Oh my G*d, what's happening?'

<div align="right">G(1) SF:22</div>

Having a diagnosis was only important as an indication of how quickly they needed to seek medical aid and to know whether the illness could harm their child. Education and the media campaign to raise awareness of meningitis seemed to have caused a sense of panic more than reassurance to these parents.

4.5.3 Doing the right thing

Mothers needed to be reassured that they were "*doing the right thing*" and wanted to be able to transfer responsibility for the wellbeing of their child to a health professional if they felt that they had exhausted their ability to deal with the illness or injury.

I 'phoned them [the out-of-hours clinic] *because I'd done everything and they're still poorly. I want to check that I've done everything that was correct.*

<div align="right">G(1) NM:5</div>

They needed reassurance that they were doing the right thing and not missing a serious diagnosis.

I just would like to sort of get away from the responsibility of anything happening – it's easier just for a nurse to say – 'Look you know, everything's all right, it's fine.' Or somebody who's knowledgeable who can say - "Well look this isn't right, you need to go to a hospital".

<div align="right">G(1) NM:17</div>

Participants expected to receive reassurance from the staff at the out-of-hours clinic, whom they assumed would calm them down, reduce their level of panic and their over dramatization of their child's symptoms.

As a mother you know when your child's ill and you've got yourself worked up into a state anyway, my mind starts wandering and I keep on playing out all these scenarios. I just get panicky because I don't know any different and I just need someone at the end of the 'phone to say 'Right, this, this and this. You've gone too far ahead, yes, all right, he's got a rash, so what!'

G(1) NM:16

The urgency to transfer responsibility to a health professional was increased if they were concerned that their child's illness could be transmitted to their siblings. Mothers perceived that the younger the child, the more susceptible to infection they would be.

My son was about 18 months old and my other son was about two weeks old, he had croup, and I've never experienced croup before; I thought he was going to die, it was just this hideous sound and I rang the doctors and just said – 'What is this? What's happening?' And my other son was born five weeks early so he was really tiny and I was terrified that the baby was going to get it and keel over. It was awful.

Iv(2) NM:1

Mothers with more than one child were less likely to consult a doctor if their child had a minor illness than those with one child. This may be because there were other children to consider or because they had more confidence and experience in dealing with childhood illnesses than a first time mother who was more anxious.

That was me thinking – 'I can't go to the doctor, there's another little child here.'

Iv(3) NM:25

As a first time Mum, I suppose I think - 'I wonder if I am just over reacting?' I know that they often say if you've got a second child you kind of get on with it and you don't really bat an eyelid at certain things because they are all fine.

Iv(2) SM:19

The time of day influenced their ability to assess symptoms rationally. It was more frightening if their child was unwell in the middle of the night rather than in the day, a mother was much more likely to panic when her child was unwell at night as loneliness and fatigue made the situation seem so much worse.

Late at night, the house is quiet, you are sat down, you are not doing anything, you're tired and yeah, I think you panic more at night than what

you would in the day. Because in the day, you're busy, you don't think of it as much as you would late at night.

<div align="right">Iv(2) NM:2</div>

As some of these extracts have shown, mothers used powerful descriptors to demonstrate their highly elevated level of anxiety. They used terms such *as "terrified", "frightening", "major and absolute panic", "devastatingly bad" "worry", "going to die", "something awful", "oh my G*d"* and *"scary"* to express their sense of urgency when their child was unwell or suffering physical injury. This language was in contrast with their less powerful terminology such as *"whingers"* and *"get on with it"* that they used as they recalled illnesses within themselves, indicating that an illness in their children was much more frightening than if it occurred in them when they "*just had to get on with it*".

I can't think ever of a situation in my life where I would ring out-of-hours service if I didn't have children. I think you just take another pill and wait until tomorrow. I hadn't really thought of it before children. You just carry on because you have to and if you feel ill because nobody else is going to look after them [children]*, you just keep going don't you?*

<div align="right">Iv(2) NM:1</div>

Mothers would consider contacting the out-of-hours clinic for themselves only if their own health had deteriorated so much that they were concerned that they might not be well enough to look after their children, particularly if they were on their own.

I called the out-of-hours doctors because being here on my own with the pain and having no one here, in case [child's name] *woke up and I couldn't look after her* [child's name]*. With him* [husband] *being away, it's only me here; you know, I've got no one to look after* [child's name]*, it's all on me. And not being very well, obviously makes things a hell of a lot worse and I need to be well enough and strong enough to look after* [child's name]*.*

<div align="right">Iv(3) NM:30</div>

4.5.4 Fear of accessing services inappropriately

Mothers were concerned about over reacting and of accessing services inappropriately and so wasting the health professional's time, reporting that they - "*feel really guilty having to bother the nurses or doctors*" or "*being stupid and neurotic when you're at the end of your tether*". Mothers spoke of using external sources as a valuable source of advice such as *"just go to Boots* [pharmacy]*"* or a pharmacy where they could receive advice. Fathers preferred the less personal approach and used the internet.

I usually search on the internet, look up the symptoms on the NHS website, we get the symptoms and then we 'phone the NHS Helpline because then we are already clued up. You know if she's [daughter] *got a small rash or something, a minor problem, I usually search on the net such as 'chest signs', if it's more urgent I'll 'phone someone.*

<div align="right">G(1) SF:23</div>

Some spoke of a *"waiting game"'* and hoped that their child would get better without seeking the help of a health professional.

The boys have been ill in the night and I've thought - 'Right, we'll just wait till the morning and see how we go'. And then in the morning, I either make the decision to go to the doctors or I don't.

<div align="right">Iv(2) NM:2</div>

Mothers consulted with their friends and family for a second opinion to ensure that they were not over reacting.

I tend to use people around me to say - 'Oh no he's fine', or - 'He needs to see somebody'. I think people do refer to their friends quite a lot, you ask your friends - 'This has been happening, this has been going on'. My Step-dad's a Paramedic, I 'phoned him to see what her temperature should be, he told me at 39ºC that I should take her to see the doctor as well, which I knew anyway.

<div align="right">G(1) NM:15</div>

Also, mothers did not want to make a fuss.

We waited 'till Monday morning, yes, our child was sick, but we took it upon ourselves to decide, because we don't want to make a fuss on the weekend; there's other people that are more ill.

<div align="right">Iv(3) NM:27</div>

Mothers weighed up the need for reassurance with making the right decisions when their child was unwell.

You don't want to be seen as an over-anxious mother for one, but you know you don't want to take chances.

<div align="right">G(1) NM:17</div>

On the other hand, one of the fathers appeared not to be so concerned about what health professionals thought.

If my child needs to be seen she needs to be seen, I don't care if I'm wasting anyone's time, I just need to get my child sorted

<div align="right">G(1) SF:22</div>

Some mothers used the call handlers or nurses to act as gatekeepers for the doctor and were more concerned about contacting a doctor unnecessarily rather than a nurse.

> *What we had in* [British Forces] *Germany was brilliant actually. There was an out-of-hours service and there was a nurse on call and then you would go and see the nurse and if the nurse was satisfied that everything was all right, you were fine. If not, the nurse was responsible for calling out the doctor, so you felt as if you weren't wasting the doctor's time.*
>
> G(1) NM:16

4.5.5 Inequity of service provision

The non-serving mothers debated the inequity of service provision for non-serving members of Army families. Serving parents were automatically registered with their local garrison's medical centre and dental centre, while the non-serving mothers and children had to find and register with a local doctor and a dentist; this was sometimes very difficult as there were long waiting lists. As soon as their names reached the top of the waiting list they seemed to be 'posted', then they would have to move to another location, which compounded the frustrations of "*starting all over again*" discussed in Section 4.3.2. Access to other health professionals was difficulty also.

> *It took me over twelve months to be able to register myself and my two daughters with a dentist, which didn't seem fair. The only other option open to us was going private, which was extortionate. My husband gets the freedom to see a dentist or any other health person such as a physio*[therapist] *whenever he wants and that freedom isn't afforded to us as families.*
>
> G(1) NM:17

This led to the non-serving mothers feeling that the Army were discriminating against Army families in the UK. Non-serving mothers who had lived in Army garrisons outside the UK found the discrepancy of primary dental and health care provision between serving and non-serving members of Army families in the UK hard to understand. This was because the whole family were registered automatically at the garrison's military medical and dental centre during postings abroad, irrespective of their serving status.

> *It's easier to have never have had something rather than to have had it and lost it. I mean we came from* [British Forces] *Germany after seven years where all your dental treatment, your medical treatment is all there for us. I don't understand why it is so different here.*
>
> G(1) NM:8

They felt better 'cared' for abroad as they did not have to fend for themselves.

> *I just think in* [British Forces] *Germany the Army take care of you a lot more and over here in UK you are just left to your own devices. When you are overseas, they* [Army] *cater for anything medical-wise; you know dentist, eye test, free prescriptions, anything. There is nothing that you had to sort of fend for yourself for unlike back here when you have to do it all yourself.*
>
> Iv(2) NM:2

Mothers who had lived in British Forces Germany spoke of their shock at the difference in primary health care provision between the UK and British Forces Germany for Army families. They spoke of feeling much safer abroad as Army health provision and out-of-hours care was easily accessible.

> *I was shocked when I came here from Germany where the med*[ical] *centre had the out-of-hours clinic as well and had all the Army families on its list. When I moved here to this massive garrison town with many more Army families I was shocked we didn't have the same! You can't imagine how different it is! You feel safer abroad as you've got so much more support from the Army.*
>
> Iv(3) NM:27

4.6 Use of out-of-hours services

Parents were aware of the distinction between in-hours and out-of-hours care, although obtaining the necessary treatment for their child was their priority irrespective of what time of day or which service it was. There was an assumption that in today's 24-hour society the time of day should not matter.

> *You don't think what day or time of the day it is, you shouldn't have to. In the 21st Century, you shouldn't have to think 'Well what time and day is it?' 'Cause everything is 24/7 these days isn't it?*
>
> Iv(3) NM:26

Perceptions of speed of response also influenced their choice of whether to seek help or not, the time of day made a difference in practical terms also. They did perceive that service provision was very fragmented with little communication or liaison between the various service providers.

4.6.1 Accessing an appropriate service

Parents made decisions regarding which was the most appropriate service to access for their child's illness or injury. All saw out-of-hours care as an extension of their own GP for medical or minor conditions when their GP's surgery was closed, whereas they saw ED as a 24-hour service for serious illnesses which required hospitalisation or musculoskeletal injuries that benefited from access to X-Ray

facilities. This may be because the nearest ED was geographically closer than the out-of-hours clinic for these participants.

> *I would probably go to A and E to find out if she* [daughter] *needed to go to hospital or not rather than go in the completely opposite direction to the out-of-hours* [clinic].
>
> <div align="right">G(1) NM:5</div>

> *So his leg is facing the wrong way so we'd better make it to A and E.*
>
> <div align="right">G(1) SF:22</div>

All of the participants used 'A and E' as an abbreviation for 'the Accident and Emergency department' rather than 'ED', if even they had completed some medical training.

One mother did not see the out-of-hours clinic as an option for care for her child, as she perceived that either her child would be so unwell or injured that he would need specialist treatment beyond the scope of the out-of-hours service or was well enough to wait until the next day.

> *Either he's* [baby son] *really, really poorly as in I'd have to take him to A and E, or it could wait until the next day.*
>
> <div align="right">Iv(2) SM:19</div>

Some mothers discussed accessing ED as a preference to the out-of-hours clinic. This was because they perceived that it was the only service during the out-of-hours period where they could turn up unannounced, and they would be guaranteed to see a doctor rather than having to be triaged by a nurse who may turn them away. Also, they did not have the additional anxiety of waiting for a call from the out-of-hours service.

> *If A & E is further and if I think he needed to see a doctor, I would still make the journey to A & E because I can guarantee I can sit in A & E and be seen* [by a doctor] *and my son will be sorted out. Whereas at the out-of-hours* [clinic] *I have to faff about, you have to wait for them to ring back for an appointment. You 'phone them up, you've got to tell them everything, and then they mysteriously decide whether it's an emergency or not, and if they think it is, they say - 'Right, I'll get a doctor to ring you back.' I want us to be served the first time round, you know, not have to wait. It could be an hour, you know and you're sitting there worrying, you think - 'Oh my G*d, I could just go to the hospital; I could be there within the time, the hour that it's going to take to 'phone me back, I could already be there'.*
> <div align="right">Iv(3) NM:26</div>

They found the whole process of contacting the out-of-hours service very impersonal.

> *You need something more personal, something that isn't one of these stupid answer messages, if you ring up you don't get – you know - 'If your child is bleeding out of its eyes press one! If your leg's dropped off, press two!'*

<div align="right">Iv(2) NM:1</div>

4.6.2 Weighing up the options

The decision to access out-of-hours care was influenced by many features such as distance, the degree of urgency in seeking medical aid and the amount of disruption to any other children. Mothers weighed up the options and balanced their fear of having a sick child, missing a life threatening illness such as meningitis and their wish to transfer responsibility for the care of their child who was unwell versus disruption to the rest of the family and the challenge of physically getting to the clinic. Once they decided to call, ease of access was a major factor for mothers who could not drive or did not have access to transport of their own; taxis were not always available. Mothers discussed weighing up not wanting to disturb friends who had transport by asking them to take them to the out-of-hours clinic, against their need to get their children treated. This highlighted their requirement for logistical support and a desire for home visits during times of military enforced separation. It also made them hanker after a local service within walking distance that they could access independently, which many had experienced within the garrison prior to 2006. Having to rely on others scared them as one mother explained:

> *It would be better for me to have the out-of-hours at the med[ical] centre, because I don't drive, so I could pop in with the kids, even if it was at night if I had to, in a pushchair and get them down there. When [name of husband] is away it scares me how I'd get to the NHS one. There's another thing you know with a taxi, most of the time they don't have one available. I'd have to call a friend who'd then have to bring their kids or we'd have to get a neighbour to watch their kids. It just worries me you know, if he wasn't here and that; I just think - 'G*d, you know!' I think the main thing is the distance and not being able to drive.*

<div align="right">G(1) NM:13</div>

Mothers weighed up whether to wait until working hours to see a military doctor who could access their child's medical notes, and whom they perceived would understand their circumstances, or to see an unknown civilian GP straight away at

the out-of-hours who was unlikely to know their child's medical history but could treat their child more quickly.

> *I prefer to see an Army doctor than a civi[lian] doctor personally. I have a lot more faith in military doctors. I think they're more knowledgeable about our circumstances. The fact that your husband's on deployment and you could be feeling pretty low at the moment. There's a better level of understanding of your circumstances because they are living that life themselves. I mean if something could wait until the morning, more often than not you will so that you can see someone who understands you.*
>
> G(1) NM:17

They also weighed up whether to disrupt the whole family to see a health professional face-to-face or to accept telephone advice from the comfort of their own home and avoid disrupting their other children. These mothers clearly preferred to see a health professional face-to-face rather than have a discussion on the telephone, even if it necessitated disrupting the other children.

> *I would rather disturb all my children, and get the one that's ill seen than just leave them you know and have a telephone conversation. You can always come home and put the child back to bed. So, it's not really an issue for me disturbing the children.*
>
> Iv(2) NM:2

They disliked telephone consultation as they felt it put too much onus on them to give the pertinent information.

> *I am wary about talking to someone on the 'phone, describing something, my description of it may be completely different, and they may interpret it in a completely different way. To explain something on the 'phone without seeing a picture of the person is really hard. I would rather see a person face-to-face to see rather than me having the responsibility of describing things over the 'phone.*
>
> Iv(2) SM:19

There was a perception that a health professional would be unable to make an accurate diagnosis without seeing the child.

> *Face-to-face reassures me a lot more than a telephone conversation, because they've actually seen what my child looks like, they've seen how they are reacting, or what their symptoms are. They can't really make a specific diagnosis just by questions they ask you on the 'phone until they've seen your child.* Iv(3) NM:26

However, those who did not have access to transport realised that telephone access was preferable to trying to organise transport if home visits were not an option (see Section 4.6.4).

4.6.3 Algorithms for triage

Parents disliked the use of algorithms as they felt that they were a safety net for the triage nurses, and sensed that their use distracted the nurses from treating their child as an individual with particular needs. They had little faith in NHS Direct who always seemed to advise them to see a doctor.

> *I think the algorithms of NHS Direct method is more in the interests of the Health Service and prioritizing rather than in the interest of the individual.....it's checking that they've done the right things and then prioritizing and saying - 'Yes see a doctor' or '- You need to get to A & E' or whatever.*
>
> Iv(2) SM:20

Participants assumed that using algorithms took triage nurses longer to assess their child's condition than if the nurses used their own diagnostic skills, as the nurse had to ask questions that were on the screen that might not be relevant. One father recalled his wife's experience of calling NHS Direct and spoke of her exasperation:

> *She* [wife] *'phoned up and it was literally 60-70 questions before she got anywhere. - 'Has your child got this?' - 'No', that takes her along to a different part of the computer screen. 'Has your child got this?' 'No'– takes you on to another different computer screen and it went on and on, she nearly went mad! If you spoke to a nurse or doctor who were not bound by these algorithms they would be asking you 20 very focused questions trying to tease out the history specifically to that child rather than any random child* (laughs). *It would be more direct and would cut the questions and the time probably by half.*
>
> G(1) SF:22

They expressed frustration that if the nurse or doctor knew the medical history of their child, precious time could be saved by avoiding using algorithms, particularly if the symptoms that initiated their call were serious enough to need referral elsewhere.

> *My daughter, she had heart surgery when she was five months old, so she's got quite a big history. Trying to explain that down the 'phone to somebody who doesn't know her at all. You've wasted ten minutes explaining what's wrong, why she's got a chest infection, why it's important that it's looked at; why you've got to keep an eye on her and then after all that going through the*

computer questions they tend to tell you - 'I'm sorry you need to go to hospital'.

<div align="right">G(1) NM:10</div>

The seriousness of a child's condition was sometimes interpreted differently by different health professionals, even once triage had been undertaken.

A friend of mine went to the med[ical] *centre; her daughter was running a temperature so they told her to take her to A and E. She got there and A and E said – 'Why have you brought her here with such a minor problem?'*

<div align="right">G(1) NM:10</div>

4.6.4 Expectations of the out-of-hours service

Parents assumed that the staff from the out-of-hours service should be friendly, kind and supportive and treat them with empathy. Mothers had expectations that psychological support for them as parents was an essential part of providing clinical treatment for their child who was unwell.

People that know you and know your circumstances and can understand where's your husband? 'Well they're deployed at the moment' and somebody who is going to listen to you. It's really, really important that they understand the Army. You're just emotional - you are more emotional than usual anyway, even if you don't realise it. When you've been on your own you just need somebody to reassure you, I wouldn't want some grumpy old nurse telling me to calm down and to 'speak to somebody else' or 'I'll put you through'. You don't want it to be a battle, you just want them to be kind. When you're on your own it's frightening. It's stressful enough. If you are on your own and your kids are ill, it's bad enough without ringing up, asking for help, asking for assistance, and they're not interested.

<div align="right">Iv(2) NM:7</div>

They expressed their disappointment if they were not treated with empathy, especially during times of military enforced separation, which was a time when they were forced to make decisions about the health of their children on their own when they were at their most emotionally vulnerable and had the greatest need for reassurance. In reality, the parents' circumstances were rarely identified.

When I took her [daughter] *to the out-of-hours clinic, the only real question that they asked about myself, and my husband was - 'do you smoke?' They didn't explore our own circumstances whether we were Army or anything, nothing about ourselves.*

<div align="right">Iv(2) NM:2</div>

Parents expressed a view that they were treated with distain by the NHS staff at the out-of-hours clinic, which indicated to them that the out-of-hours staff were not aware that they had undertaken considerable deliberation before calling them.

> *You know, I spoke to a nurse yesterday on triage; she was horrible to me. I felt like a complete idiot. It's a service that we should be able to feel free to use for reassurance. The person on the other end of the 'phone should embrace you and say - 'Don't worry - is that happening? That's Ok, don't worry.' So with someone to be on the other end and say - 'don't be silly!'*
>
> G(1) NM:5

One mother viewed that health staff needed some experience of Army life to be able to support them.

> *I think to understand Army families and how they work you have to have had something to do with the Army. The people* [out-of-hour staff] *on the 'phone should have some kind of insight of your life. It's really important that not only do they understand the Army but they have some experience of it and should have worked within an Army environment or been a part of an Army family to care for Army families properly.*
>
> Iv(2) NM:1

Mothers wanted doctors to be able to communicate with their child, although appreciated that they could not expect a paediatrician.

> *It would be nice to have doctors who have a bit more knowledge about children. You know I am not expecting a Paediatrician, but I am expecting someone who likes children. Sometimes the doctors are like 'Ooooooh – Yuk!' And it's nice when they go - 'Hi, can I feel your tummy?'*
>
> G(2) NM:6

However, there was an assumption that doctors joined the Army to treat soldiers with gunshot wounds rather than childhood illnesses during the out-of-hours period.

> *Doctors have joined the Army to go away to exotic places and treat gunshots and things like that and not to come back to do nappy rash!*
>
> G(2) NM:15

They expected staff to realise that as parents, they had been through a considerable amount of deliberation before deciding to contact the out-of-hours service. Army life had made them more self-reliant (Section 4.2.2) and "*tougher*", so

when their husband was at home they would only telephone for professional help as a last resort once all other avenues had been exhausted.

> *We* [both parents] *don't just 'phone willy-nilly for nothing, you know. We are phoning for a reason, because we tend to be a bit not harder, but a bit tougher, than sometimes civilians, because we've got to deal with a bit more, such as our husband's being away.*
>
> Iv(3) NM:27

They would never telephone unnecessarily "*for nothing*" or "*willy-nilly*"

> *You know, we've got more to deal with a whole lot more, I think, so we're not the type of people that just 'phone for nothing. We are not hypochondriacs, if there's something wrong we 'phone. Otherwise, we deal with it, get on with it, move on, that sort of thing.*
>
> Iv(3) NM:26

The serving fathers who took part highlighted that they were concerned whether their families would be given the support that they required if their child was unwell in their absence when they deployed. One father spoke of his anxiety that such concerns would be an unnecessary and potentially dangerous distraction for soldiers when they deployed and that such distractions could have fatal consequences. He stressed the importance of supporting Army families, not just as a duty of care, but also as a contribution to being militarily effective.

> *When we are deployed, we just need to know that our wives and children are being looked after. We've got to concentrate on what we're doing, it takes that worry away from us, we can then switch off from our family and concentrate straight on the job. So it helps us, and it helps them because we've* [deployed soldiers] *got enough to think when there's other things going on all round us without having to think about what happens when my daughter's ill, whether she'll be sorted and my wife supported . So we* [deployed soldiers] *need that extra support to know we don't need to worry about them to distract us from coming home in one piece at the end of our tour.*
>
> G(1) SF:23

Participants discussed not having a preference whether a nurse or a doctor treated their child as long as the health professional understood the pressures that they were under during times of separation. One mother summarised that it was the Army's responsibility as part of the Military Covenant to provide an out-of-hours

service that met the needs of the parent within the garrison in return for the
pressures that Army families were experiencing.

> *I just think the out-of-hours service, it should be there for us; it shouldn't be*
> *difficult for us to get too. It should be accessible and easy to get too; it just*
> *shouldn't be a fight. The Army puts us in this position and therefore I feel*
> *that the Army must sort it out really, they should look after us. The Army is*
> *bigger than just the soldiers are.*
>
> <div align="right">Iv(2) NM:1</div>

A local service

Section 4.6.2 discussed the difficulties parents had in accessing an NHS out-of-
hours service if they did not have their own transport. Parents expressed their
expectations for a local service, as so many wives were unable to drive and did not
want to be reliant upon their neighbours to drive them.

> *If you haven't got a car, you're completely stuffed! I mean 40% of wives don't*
> *drive, if husbands are deployed that is really difficult. You can't just call an*
> *ambulance as they might not warrant an ambulance, depending on the*
> *condition and you can't get on the bus with your other children. Distance*
> *does make a difference because of how far you have to travel. For instance if*
> *my husband's away and he has to take the car and one of these are ill, it's*
> *hard to get there. Whereas if the out-of-hours service was a bit closer, it*
> *would be easier, especially if you haven't got a car. Sometimes you can't*
> *always rely on neighbours, you don't know when your husband is going to be*
> *away, or my friends' husbands are away, so you basically have to rely on*
> *yourself.*
>
> <div align="right">G(1) NM:4</div>

The mothers who could drive spoke of being very concerned for fellow mothers who
might have difficulty accessing transport, particularly as young children could not
be left at home unattended.

> *I think the distance is a big problem. Before I could drive, out-of-hours wasn't*
> *as accessible to me. Now I drive, I could take friends that don't drive to see*
> *someone. I do have concerns for the wives with young children who don't*
> *drive and don't have the luxury of just getting in a car and leaving one of the*
> *children at home while you care for the other.*
>
> <div align="right">G(1) NM:14</div>

While they appreciated that a lack of transport was not unique to Army parents,
they identified that the pressure of Army life, increased their requirement for a local

service, such as living far from extended family that could provide logistical and practical support.

> *Well I think in this environment, a military environment, it's going to have to be within walking distance, because so many people don't drive, and are so far away from where their family live, so their mum say, is not around the corner to help them.*

<div align="right">G(1) NM:5</div>

Participants considered that out-of-hours care should not only be easy to get to geographically but also outside the internal military camp, known as 'the wire' (see Army terminology and definitions) to avoid the need to pass through military security.

> *So you need something that is not away from camp but not behind the wire, so if I did manage to get all the kids in the car and drive there then I have to faff about at the gate having my picture taken to get one of those stupid little tags and the car registration and all that.*

<div align="right">Iv(2) NM:26</div>

Home visits

There was a perception that doctors showed greater commitment to providing support and reassurance to parents if they made home visits rather than requesting them to visit the out-of-hours clinic, especially if the mother had the additional pressure of being on her own during times of separation. Parents viewed that disturbing their other children in the middle of the night was unacceptable.

> *That would be so much more reassuring if somebody could take the effort to come to your door, knowing it's in your hour of need, it's more reassurance that somebody's on your side. Whereas if you've got to travel out and you've got to get buses to get on the med[ical] centre, you've got to wait in the waiting room in A and E for three hours with a sick child. It just puts no confidence in either the out-of-hours or the medical services as a whole.*

<div align="right">G(1) NM:17</div>

There was an assumption that home visits no longer took place and were unlikely to be reinstated due to the risk of their use being abused and because of a lack of resources. They did not acknowledge some GPs preferred to see patients in a surgery as they had access to a greater number of diagnostic tools.

> *It would save us to have somebody who could come to you during the night, 'cause if it's easier if you are calling and you've got your children at home when you're on your own. You don't want to wake the other children to take them with you. I think you know that in an ideal world having somebody to*

come out to your door would be fantastic if the need arose. But abuse of the system would just put pay to that.

<div align="right">G(1) NM:10</div>

4.7 Impact of husband's presence or absence

There was a distinct difference between the decision-making process that mothers underwent when their husband was available for advice compared to when he was absent because of deployment or training exercises. Mothers stated that their husband's presence calmed them down and that he acted as "*the voice of reason*" which stopped them panicking.

> *If I had a medical emergency in the middle of the night, if you've got your husband behind you, who is normally the voice of reason in our house, when I'm like – 'Ooooh, they've all got meningitis! They are all going to die horribly!' And he's like 'Don't be stupid, he's hot and got eczema!.' You are more likely to ring up for less serious things if you are on your own.*

<div align="right">G(1) NM:4</div>

Another mother spoke of the irony of seeing her husband as "*the voice of reason*", as in reality she was the calm, rational partner of the couple. One mother, a midwife who was used to making quick medical decisions autonomously in her professional life, described her husband as "*neither use nor ornament*" but stated that his presence enabled her to make rational decisions when he was around. Conversely, his absence made her panic, which resulted in a loss of self-confidence in her decision-making ability when her own child was unwell.

> *I think - 'Is calling the doctor justified? Is she's* [daughter] *really that unwell that she needs to go and see a doctor?' And I'll ask the advice of - well my husband is neither use nor ornament, I'm the one that does all the talking and makes all the decisions. But it's just the fact of having him there.*

<div align="right">Iv(3) NM:29</div>

One mother stated that her husband was so *"laid back"* about the health of their children that she feared that if she took his "*too chilled*" approach "*to see if all this would calm down*" she risked not seeking medical aid early enough.

4.7.1 First or last port of call

Mothers expressed a far greater reluctance to call the out-of-hours service when their husbands were at home. They talked of a much more lengthy decision-making process. One mother discussed confirming with as many others as she could that her child's condition warranted treatment by a health professional.

> *I probably would have rung my husband at work first. If he thought there was something seriously wrong, I would probably ring my parents and if they still thought there was something, then I would probably ring the NHS Direct. Then if they then still thought I was crazy then I would probably ring the out-of-hours, but I would need so many people to tell me that I wasn't going crazy and that my son was actually poorly before I tried to see someone.*
>
> Iv(2) SM:19

On the other hand, the mother's threshold for calling was much lower if she was on her own. Many mothers acknowledged that they called the out-of-hours service for minor illnesses during their husband's absence that they would normally treat confidently on their own if their husband had been at home to calm them down.

> *When there's something wrong with your child, and your husband's away, you panic a lot more than what you do if they were home, I mean my husband reassures me, so if he's not here I just ring the out-of-hours straight away.*
>
> Iv(3) NM:30

> *When you're on your own it lowers the threshold sometimes that means that you sometimes need more reassurance that may be you would need if hubby was with you.*
>
> G(1) NM:9

> *If your child is ill in the night and something is going horribly wrong when you are on your own in the wee small hours, things can be a lot worse than actually they are, it's a lot scarier in the night. Then in the morning, you think - 'Actually perhaps that wasn't that bad after all!'*
>
> Iv(2) NM:1

Fear for their husbands' safety seemed to "*compound*" any worries that these mothers had. Many were aware that they had a much greater propensity to over react to minor illnesses and "*exaggerate*" symptoms when they were on their own. Mothers conveyed a sense of catastrophe as they discussed their panic and loss of rationality when their child was unwell when their husband was deployed. Such events occurred at the very time when they wanted to contact their deployed husbands directly but were unable to do so, adding to their level of stress and feelings of emotional vulnerability. This resulted in contacting the out-of-hours service as a first resort rather than as a last resort after consulting with others, as they did when their husbands were at home to assist with their decision-making.

Being on your own, your worries are compounded. I think when the men are away, everything becomes exaggerated. Because you're worrying about the situation, they're in, your child becomes ill, say with a cold, but they're a little bit drowsy, well that all of a sudden it could be meningitis. Because you start thinking - 'Oh my G*d my child's ill! My husband's in Afghanistan, I'm on my own. What if they have to go into hospital?' You play through that story! Your mind goes wild and you ring the out-of-hours straight away.

G(1) NM:8

Not only did they talk of deciding to call the out-of-hours service sooner than if their husband had been present, but they accessed it with a much greater sense of urgency. Participants had a palpable sense of panic as they told me of their experiences when their child had been unwell when their husband was away and the onus was on them to get their child "*sorted"* as quickly as possible.

I panicked more, 'cause I was on my own. When there's something wrong with your child and your husband's away you have got to sort the whole lot out on your own, and so it is important in your head to get it sorted there and then. You have greater urgency because I've got nobody to discuss it with, nobody there if it all goes wrong, to help. I was on my own when he banged his head I panicked the backside off myself. I just want to get it sorted before the next thing came along, 'cause there's always something else!

Iv(3) NM:26

Of all the scenarios that these mothers had to face during their husband's absence, their child being ill in the middle of the night was the scenario that they feared the most.

I just live in hope when my husband is away that my child will not be ill. It's my biggest fear is of something going wrong in the middle of the night and that [child] *is sick. In the day it's fine, it just doesn't feel as bad.*

Iv(3) NM:28

4.7.2 An accumulation of stressors

What makes Army mothers stresses different is the likelihood that, irrespective of their serving status, they have to cope with such an acute accumulation of life stressors at the same time. They spoke of moving home, loss of their extended family and long-term friends living nearby to provide emotional and psychological support, military enforced separation from those they love, coping with their sick child, at a time of immense emotional stress when they feared that their deployed husband would be seriously injured or killed. The following extract from a non-serving 'Army wife' and mother exemplifies the reality of being exposed to so many

stressors at once, which she perceived had "*totally destroyed us*" when in reality she had 'coped'.

> *I moved back from* [British Forces] *Germany to UK on my own with three children and a slightly mad dog when my husband was in Iraq, and the children had to start new schools, nurseries, new everything and they were utterly upside down for months. My son had croup I thought he was going to die. But I thought - 'Am I being paranoid because I'm on my own with no one to ask?' It was awful having to cope with so much at once but I did because I had too. It is frightening when he's away and really, really frightening when you're on your own when your children are ill.*

> G(1) NM:1

4.8 The cathartic benefit of participation

Many mothers spoke of the cathartic benefit of participating in this study as it enabled them to talk about their experiences and made them feel valued.

> *It's really good to talk to you about it* [Army life and the decisions that they made when their child was unwell] *I told lots of women that you were coming today and they were like – 'Wow! Somebody's actually noticed us; somebody's taking notice of our out-of-hours care!'*

> Iv(3) NM:27

The parents that participated in the focus groups were delighted to find that others shared their views and that they were not isolated in their experience of the daily challenges of Army life.

> *I think it's nice to know that you are not on your own, and that you are not thinking the same things. Sometimes you just think and sit and mull over things at home thinking - 'Is it only me in this position? Is it only me just like this.' And it's nice to know that there are other people are in the same position as you are and you are not alone.*

> G(1) NM:12

The mothers who took part in a one-to-one interview found it liberating to be able to express their views freely, uninterrupted, in confidence without being judged. One participant had a breakthrough during her interview as she verbalised her story of the recent events of when her son had been unwell during her husband's deployment. She was still reflecting upon the incident and how she had coped at the time of the interview. As her interview progressed and she reflected upon how she had handled this situation, her language changed from that of a disempowered victim such as "*I felt useless*", "*this is just too much for me*" to becoming an empowered survivor "W*ow! I did it!*' She contacted me after her interview to

express her gratitude, as the simple act of telling me her story had altered her previous self-image from a "*failed*" mother who had not coped, to an emotionally strong and empowered woman who would rise to any challenge in the future.

Other mothers highlighted that taking part in an interview with me was the first opportunity that they had had to talk about their feelings and experiences to an impartial listener, as they had not felt able to talk through any of their experiences or emotions with anyone else. They spoke of reduced feelings of emotional isolation that had occurred as a result. Any meaningful communication with their deployed husband was impossible because of the restriction in telephone call opportunities, duration and the time delay, particularly if there was a communication embargo because of an incident that has occurred at the time in which soldiers had suffered serious or fatal injury. They did not feel it appropriate to talk to their Army friends who were undergoing similar challenges for fear of their friends sensing that they were not coping; they assumed that their civilian friends would not have any concept of what Army life was like. None of the mothers had extended family living nearby, so most communication with their own parents and siblings was via the telephone. All spoke of not wanting to worry their extended family by "*whingeing*" on the telephone as the following excerpt demonstrates:

> *I have found it extremely helpful just talking to you. It's been the first time I've had the opportunity, because as I said before, as my husband cannot contact me, I haven't got his evening 'phone calls, and I wouldn't really burden this on my mother – on my family. My mother said the other night – 'You are not OK are you?' And I said, 'Yeah, I'm fine'. If I'd said - 'Well I'm not OK', I know she would worry. My Army friends are in the same boat so I don't want to whinge to them when they've got enough to deal with.*
>
> <div align="right">Iv(2) NM:2</div>

They concluded that opening up to their Unit Welfare Officer was not appropriate either as even if they knew who he was, they perceived that he had other priorities that were more important than listening to them when he had logistical welfare issues to address.

4.9 Summary of the findings

The participants gave a vivid description of how Army life impacted on them as Army parents and how it influenced the decisions that mothers made when their children were unwell. However, just like civilian parents, mothers feared missing a serious illness in their child such as meningitis. Mothers acted as protectors for their children, not only to safeguard them

for suffering when they were unwell, but also as an attempt to shield them from the disruption of Army life.

The data have highlighted that mothers faced an accumulation of stressors as a result of living within an Army environment. Interviewing Army parents, as a group or individually, illuminated the complex features of Army life, the context in which Army mothers lived and the challenges they faced. These challenges were greatest for Army mothers when their child was unwell and they were a lone parent during a period of military enforced separation. Daily disruption, frequent mobility and military enforced separation were such an integral part of their lives that it had a major influence on all aspects of their lives and had a major psychological impact on these Army mothers. Difficulties planning in the short, medium and long term were practical examples of how they experienced the disruption.

The findings have given clear examples of the factors that influenced these mothers decision to consult and how the decision-making process of the mothers who participated in this study was influenced by the husband's presence or absence. I have developed the mother's decision-making process and the features that influence it into an algorithm that can be seen in Figure 4.1 (on the following page).

Figure 4-1 Mother's decision-making process

```
┌────────────────────────────────────────────┐
│      Mother identified that child unwell     │
│         e.g. by change of behaviour          │
└────────────────────────────────────────────┘
                      │
┌────────────────────────────────────────────┐
│              Assessment of child             │
│  e.g. check temperature, degree of distress, │
│              not eating                      │
│        Trying to make sense of the injury    │
│  Attempt to manage problem e.g. give medication │
└────────────────────────────────────────────┘
                      │
              ┌───────────────────┐
              │ Is husband present? │
              └───────────────────┘
```

Contact others for advice
e.g. family, friends, internet, pharmacy, NHS Direct

Need reassurance of second opinion
(Due to fear of missing serious illness, need to transfer responsibility, fear of accessing services inappropriately)

Assess symptoms
Decide if can control symptoms
Weigh up situation e.g. disrupt other children versus fear of missing serious illness

Discuss, share decisions with husband
Reassess if can control symptoms

Monitor child's condition

Yes →
No →

Decide to seek health professional

FACTORS AFFECTING DECISIONS

Psychological
-Loss of voice of reason
-Loss of shared decision-making
-Degree of emotional vulnerability
Degree of fear, anxiety and fatigue
Practical
-Time of day (day or night)
-Access to transport
-Care of other children
-Previous experience
-Expectations of health services
-Medical knowledge

Assess which service appropriate considering time of day and seriousness of injury/illness
**e.g. GP, ED, out-of-hours service**

Figure 4.1 illustrates that mothers continually assessed whether they felt in control of their child's symptoms. It demonstrates also, that mothers called the out-of-hours service when their child was unwell without consultation with others when they were alone. However, when their husbands were present to assist in the decision-making, they confirmed from as many sources as they that their child's condition warranted assessment by a health professional and after considerable debate. The husband's absence resulted in a short-circuiting of the mother's decision-making process and so influenced whether or not she called a health professional as a first resort or a last resort once all other avenues of advice had been exhausted.

Parents developed many strategies to enhance their ability to cope. The need to develop specific coping strategies, such as establishing a network of social support to enhance their ability to cope, was a key finding. Their decision to consult a health professional was influenced by both their emotional state, such as whether they felt they could cope emotionally, as well as practical issues such as transport. This was vividly illustrated during times of deployment when dealing with their child being unwell seemed to challenge their ability to cope the most.

Mothers prepared themselves for news that their husband would be fatally or seriously injured during times of deployment and training exercises, while hoping that he would return home unscathed. This created a conflict of emotions and a sense of ambiguous loss. The development of a social network of support with their neighbours was a key way to reduce their feelings of isolation and loneliness. Developing an identity as an "*Army wife*" seemed to be a major contributory factor to help them to cope also. These strategies will be discussed in light of the theoretical literature in the next chapter.

Chapter 5 Discussion

5.1 Introduction

Chapter 4 provided a comprehensive in-depth insight into the reality of being an Army parent with a child who is unwell during a period of intense military activity. This discussion considers the findings presented in Chapter 4, compares and contrasts them to the literature in Chapter 2 and offers a theoretical explanation for them. This chapter demonstrates how this study has enriched the existing evidence, and so facilitated a greater understanding of an Army mother's decision-making behaviour when her child is unwell during the out-of-hours period.

The practical and psychological impact of the distinguishing features of Army life (such as military enforced separation and frequent mobility) on parents was strongly documented in both the military literature and the findings. It was very evident that the greatest fear for the Army mothers in this study was that their husband would be killed or seriously wounded. As a result, the data was dominated by their need to 'cope' if their child was unwell during times of military enforced separation. Participants spoke of the challenges as both practical and psychosocial. For example, the constant disruption to daily life raised practical problems regarding childcare. The impact that Army life had in practical terms was similar, regardless of the mobility or the cause of the separation. Also, becoming a lone parent with access to limited transport caused a sense of loneliness and loss which created psychosocial challenges. These features had an impact on the decisions they made when their child was unwell, particularly if they were making decisions alone.

The disruption of Army life and military enforced separation were themes that were expected as they were well represented within the literature. However, the consistent strength of emotion that these features generated and the degree to which they affected a mother's decision-making was surprising and under-reported in the literature. Other data raised other issues that had not been investigated in the military or civilian literature, such as how a sense of belonging impacted on a mother's decision-making. Findings were analysed in terms of the strength of the evidence in light of the current research and general literature.

'Coping' is a term used frequently in the military literature; however, it is not often defined by researchers to clarify how they have interpreted the term in their study. Carver and Connor-Smith's (2010) definition of coping is highly appropriate in light

of the literature reviewed and the data analysed from this study. Carver and Connor-Smith's (2010, p 685) define coping as the *"efforts to prevent or diminish threat, harm and loss, or to reduce associated stress".* Much of this chapter focuses on the factors that enhanced and challenged Army mothers' efforts to 'prevent', 'diminish' or 'reduce' and so manage and 'cope' with their stress. The participants gave convincing examples of how they felt the Army both ameliorated and thwarted their ability to cope. The constant disruption of events and inability to plan hampered their ability to feel in control. The more control they tried to establish over their lives, the more obvious their lack of control was. For example, the times or dates of an event such as a training exercise would change frequently to disrupt their plans. In other ways the Army boosted their ability to cope, for example, Army welfare provision was a potential benefit which they could use to counteract the loss of social networks caused by frequent mobility. The data demonstrated that most parents had accepted that mobility and separation were necessary in order to meet the needs of the Army. Also, an inability to control events in their daily lives was a hazard of Army life. Participants talked of having little or no control over where and when relocation would take place, and so mirrored Dandeker et al's (2006) conclusions. One mother, although providing a lone voice, viewed it as a conspiracy to destroy families.

The findings illustrated that while the Army attempted to ameliorate the impact of the disruption of Army life, its ability to do so depended on the willingness of its parents to engage with the support offered. Capitalising on a social network of support by interacting with their neighbours reduced the participants' feelings of isolation and loneliness and bolstered their ability to cope. However, in order to do so, participants had to be willing to trust and interact with their neighbours to benefit from being offered practical and psychological support. Their willingness to engage with this support appeared to be influenced by the mother's degree of allegiance to the Army. As a result, adopting a strong sense of belonging and identity with their Army community was a vital coping strategy used by these mothers. This reduced the loneliness and isolation associated with mobility and separation and so bolstered their resilience and ability to 'cope'.

The data suggested that Army mothers engaged in certain behaviours to *"reduce associated stress"* (Carver and Connor-Smith 2010, p 685) and so lessen their emotional vulnerability. Enhancing a sense of identity and belonging reduced their sense of loneliness and isolation and so bolstered their resilience and ability to survive emotionally. Facing such challenges together as a group of Army wives

seemed to make Army mothers an exceptionally cohesive body. They supported each other, particularly through times of deployment when they shared a common fear for their husband's safety and when the emotional turmoil that this created was at its height.

The consistent use of the term "*Army wife*" rather than 'mother' or 'parent' in both the military literature and the data indicates that a sense of belonging to a group with which Army mothers identify is an important coping strategy for them. This is an example of how the data demanded an exploration of the theoretical literature to explain why parents and the Army as an organisation placed so much emphasis on the role of the "*Army wife*". Furthermore, it was crucial to establish why Army mothers found Army life such a challenge that it had an impact on their decision-making behaviour. However, the data demonstrated that the degree of belonging and the extent of feelings of loneliness and isolation differed depending on whether the mother was part of a Regiment or Corps. Feelings of belonging and identity are clearly important, yet 'belonging' as a term was only mentioned within the literature by Dandeker et al (2006).

Synthesizing the theoretical literature has been integral to conceptualising how belonging, identity, resilience and ambiguous loss feature within an Army environment. As a result, the theoretical literature is woven throughout the discussion. This has enabled me to contrast how these concepts are displayed within the data compared to the reviewed literature. The concept of ambiguous loss is explored in greater depth than was undertaken for the literature review, as fear for the husband's safety was found to be such a significant and powerful finding. Identifying which strategies were used within the context of the study has enabled me to construct what the term 'coping' as a mother within an Army environment means.

The findings also provided robust evidence to support the description of Army life in the military literature. "*Military Family Syndrome*", described by LaGrone (1978, p 1041), "*the peculiarities of Army life*" spoken of by Vincenti 1990, p 78) and Dandeker et al (2006, p 400) "*non-negotiable*" aspects of Army life, were demonstrated to be a reality for the participants in this study. This confirms that the Army as a population is different from the civilian community within which it resides.

This chapter is divided into three sections in order to identify the impact of Army life on the decisions that mothers made when their child was unwell during the out-of-hours period. The first section interprets the coping strategies used by Army mothers (Section 5.2.). The second section evaluates the decision to consult (Section 5.3), while the final section considers how Army life differs from civilian life (Section 5.4).

5.2 Coping strategies used by Army mothers

In light of Carver and Connor-Smith's (2010) definition, 'coping' in the context of this study is concerned with Army mothers' ability to manage the challenges that they face and the emotions that they experience, particularly when their child is unwell. The psychologist Lazarus (2006) conceptualised a theory of coping, describing it as *"an integral feature of the emotion process"* (Lazarus 2006, p 10) as it relates to how an individual interprets stress and how it affects their wellbeing. He theorised that stress is likely to remain under control if coping strategies are effective, but if they are not, damaging consequences on health, morale and social functioning are likely to result. Lazarus (2006, p 10) concluded that assessing a person's ability to handle their stress necessitated an assessment of both 'the person' and 'the context' in which they are living. The following section assesses the strategies that Army mothers in this study (the person) used within an Army garrison at a time of frequent military enforced separation (the context).

Army mothers developed many strategies to handle living in an environment in which they perceived that they had little control. Mothers in this study clearly stated in their own words that having to "*cope*" with such challenges made them a "*stronger*", a more "*flexible*" individual who was able to "*bounce back*" (Section 4.2). They interpreted 'coping' as a personality trait rather than as a strategy that included practical ways to ease the burden of Army life. They compared their situation to that of the civilians in their local community, as well as their friends from childhood who were still living in their own town of origin. They believed that Army mothers "*coped*" with stressful situations much better than civilians did as a result of their perception that they had to cope with more challenging circumstances. This reflects the Korean researchers, Lee et al's (2004) interpretation of what resilience means in their work regarding the concept of resilience in the context of coping with caring for a chronically sick civilian child.

Lee et al (2004, p 636) interpreted resilience as an "*enduring force*" that caused a family's dynamics to change so that they could cope with the problems that they

encountered. Lee et al (2004, p 639) acknowledged coping to be a problem solving process. They viewed it in terms of the individual's ability to maintain a sense of control to help them to recover easily or "*bounce back from unpleasant damaging events*". The military literature (such as Fitzsimons and Krause-Parello 2009 and Davis et al 2011) referred to resilience as an important strategy but did not define what was meant by the term. Lee et al's (2004) work demonstrates that understanding the term resilience gives insight into what the term 'coping' means also.

The discussion in Section 2.4.2 confirmed that coping strategies are thought to be emotion-focused or problem-focused (Leventhal et al 1967; 1983; 1998). As Carver et al (1989) identified in their theoretical paper of the assessment of coping strategies, problem-focused coping aims at problem solving or doing something to alter the source of the stress. Emotion-focused strategies aim to reduce or manage the emotional distress associated with or caused by the situation (Carver et al 1989). Mothers used both strategies, such as setting up social networks to enhance their emotional support, or deciding to take active measures such as trying to "*avoid the news*" as a problem-focused protection mechanism when their husband was deployed. Many of the participants did not overtly view enhancing their social network as a coping strategy. However, in reality that was what this was, as it reduced the emotional distress associated or caused by the situation. Using a problem-focused approach gave them the chance to do something to alter the degree of stress that they were experience as they could not remove the source of their stress, caused by their husband's absence.

Lee et al (2004, p 639) suggested that an individual's ability to cope depended upon *"internal"* and *"external"* factors. They deemed *"internal factors"* to be inherent characteristics, such as the vulnerability of individual family members, while external factors were depicted as the "*hassles*" of daily life and stress that accumulated over a long period. This explains why the data and the military literature confirmed that some mothers seemed to 'cope' better than others did. Some participants identified that they must be emotionally strong and "*resilient*" and that any hint of not being able to *"cope"* was a sign of weakness. Giles (2005) recognised that her participants feared consulting their GP as this indicated that they were struggling to cope. Lee et al (2004) acknowledged that flexibility, a positive outlook, a sense of control (balancing), adaptation (adaptability), social integration and resourcefulness were common attributes to aid resilience.

According to Lee et al's (2004, p 638) theory, constant exposure should boost the mothers' 'internal factors' and buffer them from stress. The Army mothers who had been part of the Army for many years stressed that the longer they had been an "*Army wife*", *"the stronger and tougher"* they had become. It was as if constant exposure to the challenges of Army life made them more resilient and 'buffered' them from the rigours of Army life. Paradoxically, Giles (2005) and Dandeker at al (2006) identified that the mobility of Army life eroded a mother's ability to cope over time and made her more emotionally vulnerable. It was apparent in this study, that the longer mothers had been an "*Army wife*", the greater the chance of accumulating the 'external factors' or the "*hassles*" that Lee et al (2004, p 639) recognised. For example, many of the participants stated that relocation became more monotonous every time they moved, even though they had got used to the process which made the practical issues easier to manage.

Fisher and Shaw (1994) investigated the impact of corporate relocation on Australian employees. They concluded that the more frequently a family relocated, the more quickly they adapted and settled into their new surroundings because of an increased familiarisation with relocation procedures and a more realistic expectation of the impact of moving. This explains why Army parents wanted to settle into their new location and make friends as quickly as possible. There were harsh consequences such as feelings of loneliness and emotional vulnerability if they did not. It can be hypothesized that they were trying to boost their own confidence by believing that they were 'resilient'. In reality, the degree to which the husband's absence and the disruption of Army life altered their decision-making process when their child was unwell indicates that they were more emotionally vulnerable and less resilient than they would have wished, as Giles (2005) reflected in her findings. Both the findings and Giles's (2005) work confirms that being 'seen to cope' is very important for Army wives.

Matthiesen and Tissington (2008) reviewed the existing theory and research on the consequences of relocation for civilian employees and their families. They suggested that relocation is challenging because it demands a major adjustment in three major areas of the lives of those moving:

> (1) The environment or geographical location (including housing and facilities).
> (2) Relationships (such as the help and support network available.
> (3) The change in working life due to the change of post.

Matthiesen and Tissington (2008) acknowledged that frequent mobility creates a loss of deep-seated relationships and hinders the development of new ones, creating a sense of isolation and loneliness regardless of how safe an individual feels. They postulated that relocation requires a major adjustment. This is because it disrupts the routine of the whole family and not just the employee who is changing post. It forces each family member to adjust their behaviour and adapt to change. This creates anxiety and a sense of emotional vulnerability. Individuals try to combat this by establishing new friendships, as reported by the participants in this study. Matthiesen and Tissington's (2008) work indicates that establishing new friendships helped individuals to develop a sense of belonging and identity with their new community. However, both the military literature and the data confirmed that this was difficult in practice, particularly for children. Parents reported that their children did not seem to adapt to the emotional upheaval. One mother in this study reported that her more recent house move had caused her children to be "*utterly upside down for months*". Clifton (2007) concluded that children protected themselves emotionally by keeping their distance. She concluded also, that Army families who moved house frequently adopted the organisation as an extended family in the absence of their own, which also proved to be the case for the participants in this study, particularly the Regimental families. Giles (2005) acknowledged that frequent mobility eroded Army wives' ability to cope, which contributed to their attendance at their GP being more frequent than that of civilian wives.

Kirschenbaum and Weisberg (2002) investigated the impact of relocation on 477 employees from 15 companies in Israel. They recognised that employees' job mobility and flexibility are seen as an important aspect of organisational performance. They deduced that relocation is more stressful to individuals if the relocation is for the benefit of the employer rather than the individuals or their families. Liljegren and Ekberg (2008) concluded from their survey in Sweden that job mobility within civilian life had better health outcomes, such as reduced work-related stress, if those relocating had control over when and where they moved.

The Ministry of Defence (2008a) warns that Army personnel have very little control over where and when they move and may be required to move far away from the support of relatives and friends. Such limited control may account for why this study's findings featured a lot of evidence regarding the negative aspects of mobility. Frequent mobility created an internal conflict within these parents as it challenged their personal beliefs and values. Army parents understood that their

priority must be to meet the needs of the Army, but in reality, meeting their children's need for stability in such areas as schooling and locality was more important to them.

Ammons et al (1982) investigated the stress caused by civilian corporate moves. They recognised that transient communities with a rapid turnover of community members were friendlier and offered more support than those who were more static. This explains why participants talked of trying to settle into their new location as quickly as possible by making a conscious effort to make new friends and of unknown neighbours turning up on their doorstep with a bottle of wine or food to welcome them to the area. Both those already living in an area as well as those moving into it needed to enhance their friendships; one mother reported that there was a constant flow of families moving in and out of the area. Parents seemed to make a great effort to reduce the impact of their nomadic lifestyle on their family, using different techniques to alleviate feelings of isolation and loneliness caused by living far away from extended family. Giles (2005) and Dandeker et al (2006) concluded that the constant cycle of postings caused Army wives to suffer from stress. This did not seem to be the case in this study as parents talked of the tedium of relocation rather than their inability to cope with it. Participants realised that living in the stability of their own home in a civilian community away from the Army would risk opting out of the social network that the Army offered them. This lifestyle choice could also increase separation from their husband and so exacerbate their sense of loneliness and isolation.

The Army's continued commitment as an organisation to the provision of welfare support, particularly during times of deployment, demonstrates its awareness that Army life challenges its families. Participants talked of Unit Welfare Officers' working hard to develop social networks by organising social events such as coffee mornings to encourage Unit cohesion. The positive contribution of the Unit Welfare Officers that was reported in the data is consistent with the military literature (such as Giles 2005 and Dandeker et al 2006). However, the data did not reflect Giles's (2005, p 215) findings that Unit Welfare Officers were "*out of touch*". The data included accounts of participants getting to know their neighbours, as well as other families in their husband's Unit. Mothers gained practical benefits from this, for example sharing childcare, as well as psychological benefits which reduced a sense of loneliness during times of military enforced separation. The evidence in the data of the development of support networks within the military community, particularly

when Army wives were at their most vulnerable during times of deployment, reflects Dandeker et al's (2006, p 381) findings that this is a method of "*stress buffering*".

Shaw (1999) recognised that social support plays an integral part in the coping process (see Section 2.4.2) and acknowledged that a lack of extended family nearby to offer psychological and practical support added to parental levels of fatigue. This in turn increased the need for reassurance in their decision-making abilities when their child was unwell. The participants gave clear examples of this, the findings confirmed Shaw's (1999) view that social support plays an integral part in the coping process, even if it is perceived rather than actual support.

Most participants acknowledged that the consequence of choosing not to get involved with other military families in their location was to risk isolation from their community and the loss of emotional and practical support, particularly if the one of their children was unwell when their husband was deployed. These were all examples of adaptive problem and emotional-focused coping strategies that if adopted, bolstered their emotional relationships and enhanced their ability to handle difficult situations.

It can be hypothesized that the few mothers who chose to opt out of getting to know their neighbours, may have done so as an active problem-solving coping strategy to protect themselves emotionally. Others found that getting involved was a better active coping strategy. This confirms Leventhal et al's (1967; 1983; 1998) theory (discussed in Section 2.4.2) that most stressors elicit both types of coping. The data demonstrated that using a problem-focused approach appeared to predominate when mothers felt that something constructive could be done, such as getting to know their neighbours so that they could develop meaningful relationships. An emotion-focused approach tended to predominate when the stressor needed to be endured, such as separation and loneliness during times of deployment. Most lived far from any extended family and so were unable to call upon them to provide practical and emotional support. As a result, they had to think of other ways to gain such support. Trusting neighbours gave participants the freedom to leave their children safely in their neighbours' care in an emergency, even if they had never met them before. Participants were aware that this was not a luxury afforded to civilian communities, in which such behaviour might raise concerns regarding child protection and irresponsible parenting. Two mothers whose husbands were serving with a Corps did not seem to trust their neighbours for fear of being targeted by gossip. However, they realised that this risked

isolating themselves as it relinquished the chance of making close friendships with their neighbours. Also, this made social interaction without the children almost impossible during times of separation when their husband was not able to assist with childcare. As a consequence one spoke of lacking *"forever friends"* like those she had in her town of origin. In contrast, others who trusted their neighbours talked of other mothers as their *"family".*

Montalbano-Phelps (2003), in her qualitative research with civilian wives suffering domestic abuse, recognised that the participants' trust of the researchers enabled them to disclose their experiences and resulted in the empowerment of the participants. This may explain why the mothers who were attached to a Corps specifically expressed how cathartic they had found taking part in the study. Just like the participants who contributed to Montalbano-Phelps's (2003) study, participants acknowledged that trusting me to hear their story without judgment reduced their feelings of isolation and increased their sense of empowerment. The cathartic benefit of taking part in research is well recognised (for example see Peel et al 2006 and Clark 2010), although it was not identified in the literature reviewed. Thus, trust was an important issue for these participants. While this was not raised as a specific theme within the reviewed military or civilian literature, a lack of trust explained some of the findings in the military studies reviewed in Chapter 2. For example, LaGrone (1978, p 1042) acknowledged that the local civilian community distrusted military families because of their transiency. A lack of trust explains why the mothers participating in Giles's (2005) study were reluctant to acknowledge their concerns with their GP and why the children participating in Clifton's (2007) study found forming meaningful relationships difficult.

Baumeister and Leary (1995, p 499), in their theoretical review of the concept of belonging, identified that forming groups to share resources in times of scarcity and achieving group membership can create cohesion and social bonds of support. Also, supportive relationships provide a buffer against stress. This explains why the creation of social networks proved to be such a positive active coping strategy for Army mothers in both the findings and the military literature. Social networks could be used *to "prevent or diminish threat, harm and loss, or to reduce associated stress"* (Carver and Connor-Smith 2010, p 685).

Levett-Jones and Lathlean (2009) used a mixed methods study to explore the experience of belonging within a population of civilian student nurses. They concluded that student nurses can only become competent clinically if their needs

for safety, security and belongingness are met. This study investigated the experience of belonging with student nurses rather than Army parents. However, it illustrates that group conformity (which takes place within the Army) has a major impact on an individual's feeling of belonging. Levett-Jones and Lathlean (2008, p 103) acknowledged that group conformity had a major impact on an individual's feeling of belonging.   They identified that failure to belong may have "*devastating*" consequences, such as lowered self-esteem, increased anxiety and a decreased sense of happiness and wellbeing, thus creating feelings of social isolation, alienation and loneliness. This may be why mothers in this study whose husbands were serving with a Corps (rather than a Regiment) talked of greater feelings of loneliness than the Regimental wives, just as Giles (2005) and Dandeker et al (2006) concluded. Families from Corps did not move *en masse* and so did not have such an established social network or an equivalent sense of belonging of the Regimental families.

One of the earliest definitions of belongingness was outlined by Anant (1967, p 391), a civilian social scientist, as "*the extent to which an individual feels that he is an integral part of the environment or system that he is a part of*". American civilian researchers, Hagerty et al (1992, p 175) developed this definition by identifying two defining attributes. The first attribute concerned the experience of being valued, needed or perceived as important within the environment or group of which one is part. The second attribute of belonging involved the experience of "*fitting in*" through shared or complementary characteristics. The importance of "*fitting in*" formed the basis of civilian psychologists Baumeister and Leary's (1995) definition of belonging in terms of contributing to one's sense of "*connectedness*" and "*attachment*" to others who in return provide protection against harm.

Baumeister and Leary (1995, p 498) recognised that a sense of belonging is a "*fundamental human motivation*" within all human beings and creates a pervasive drive to form and maintain positive and lasting interpersonal relationships. This may explain why the *"common bond"* between Army parents and the importance of "*fitting in*" were emphasized in the findings as well as the military literature. Camaraderie enabled individuals to rise to the challenges of Army life that they faced on a daily basis, such as an inability to plan in the short, medium or long term. An example of how Army wives tried to fulfil their need for belonging was their development of social relationships with others in their husband's absence. This often took the form of social interaction with other mothers whose husbands were deployed and who shared their identity as an "*Army wife*". Forming

relationships reduced their sense of loneliness, particularly when their husband was deployed. This accounts for participants speaking of how the support that they gained from their peers helped them to cope as a united group against the challenges created by the Army as an organisation.

The desire to *"fit in"* was crucial for the participants in this study and may account for the mothers' need to develop a sense of identity as an *"Army wife"* and for the serving participants to choose to wear uniform. This resonates with Pratt and Rafaeli's work (1997), who undertook their qualitative research within a civilian hospital to explore how nurses used uniform as a symbol of their identity.

Pratt and Rafaeli (1997) demonstrated that organisations use uniform as a mechanism for asserting organisational control in order to increase compliance with organisational rules. Organisations use uniforms also to embed their values and beliefs in individuals and so enhance a sense of belonging and community ethos. The serving participants demonstrated their allegiance to the Corps or Regiment with which they were serving by choosing to wear uniform for their discussion or interview, irrespective of whether an officer or a soldier. Uniform visibly demonstrated to all the other participants that they belonged to a certain Regiment or Corps, as each cap badge was instantly recognised by other parents who were either serving with or a partner of a member of that Regiment or Corps within the garrison. The importance of identity was very apparent. Participants had overridden my request for them to wear civilian clothing in case the visual confirmation of their rank on their uniform influenced the discussion and inhibited the contribution of other participants (discussed in Section 3.8.3).

The identity of being *Army* parents seemed to encourage conformity and a sense of camaraderie within the focus groups. This explains why the Army places such focus on the wearing of uniform. Interestingly in this study, the only soldier who did not wear uniform during the initial fieldwork for Phase One was the mother who it transpired had decided to resign from the Army. She did not disclose her identity as a serving soldier until I interviewed her a few months later during the fieldwork for Phase Two. She revealed that she had been undertaking maternity leave when she had taken part in the focus group and wanted to disassociate herself from her identity as a serving soldier. She chose to wear jeans to *"fit in"* with the other group of non-serving Army wives rather than her serving colleagues. This theory was confirmed by another serving mother who chose to wear uniform for the focus group and proceeded to talk about the importance of allegiance to the Army.

However, when interviewed in Phase Two she was in her own clothes. Much of the discussion focused on wishing to be identified with the non-serving Army wives of her husband's Regiment as she was then on maternity leave also. It is clear that understanding the concepts of belonging and identity as well as the difference between the two is crucial to understanding why setting up social networks and wearing uniform was so important for these participants and for the Army as an organisation.

The Army places much emphasis on the importance of its Regimental and Corps structure in its most recently published guide *The Army: An introduction* (Ministry of Defence 2010b). It points out that uniform displays the distinctive Regimental or Corps emblems as well as the rank of the individual. The Army stresses that the wearing of uniform by its serving personnel instils a sense of identity and pride in serving in the Army as a whole as well with an individual Regiment or Corps (Ministry of Defence 2011c). The data emphasized that having a sense of identity with and belonging to a Regiment or Corps is a crucial part of the Army ethos. While this phenomenon was supported in military documents (such as Ministry of Defence 2010b, 2011c), there was little evidence of this in the military literature.

It became apparent that by strengthening a sense of identity the participants' sense of belonging increased also, which in turn had a positive impact on their psychological wellbeing. The data related many stories of mothers from Regiments adopting other families within the Regiment as if their own, while the military literature (such as Fernandez-Pol 1988 and Giles 2005) acknowledged that the disruption of social networks caused by frequent mobility reduced some mothers' ability to 'cope'.

Mothers whose husbands served with a Corps spoke of being lonely much more often than the mothers from Regiments, who seemed to have a greater allegiance and more established sense of belonging to their husband's Unit than those who were from a Corps. Regiments moving *en masse* enabled parents to set down 'roots' within a community that moved with them. This allowed the Regiment to become a surrogate family, as evidenced by comments such as "*the Regiment's your family*", to which they had a great sense of belonging and from which they gained a great deal of emotional support. "*Trickle*" assignments of Corps personnel resulted in these parents being unlikely to relocate together with long-term friends who might be expected to enhance their sense of belonging. Also, the welfare support offered to families depended on whether the family was attached to a

Regiment or a Corps. This demonstrated that the identity of the Unit with which the husband was serving had a major impact on the level of support available to the husband's family in his absence. These inconsistencies led to greater feelings of isolation and loneliness in those families who belonged to Corps, a finding supported by both Giles (2005) and Dandeker et al (2006).

The researchers Mellor et al (2008) concluded in their study, which investigated the relationship between belongingness and loneliness, that those who are lonely have an unmet need for belonging, irrespective of how many friends they have. This may account for the findings that some Army wives felt lonely even though they were part of a friendly military community. Mothers from Corps spoke of craving adult company and conversation. They reported feeling their separation from extended family and long-term friends much more acutely than Army Regimental wives who had known their neighbours for many years, relocated *en masse* with them and knew how to access their Unit Welfare Officer for practical or emotional support (Section 4.3.3). One mother from a Corps spoke of forcing herself to get out of the house after she had just given birth during her husband's deployment. She used this as a strategy to get to know other mothers to combat her loneliness when she was at her most emotionally vulnerable. Many wives from Corps spoke of the camaraderie of living abroad, an environment in which they appear to have developed a greater sense of Unit cohesion and therefore a greater sense of belonging. This may be because they developed the cohesion abroad that Regimental wives benefited from in the UK.

Identity theory sets out to explain an individual's role related behaviours. It demonstrates that society affects social behaviour through its influence on 'self', in which 'self' is a multifaceted construct that makes up an individual (Hogg et al 1995). Identity theory was formulated by the psychologist Stryker (1980, 2007) who proposed that individuals take on different identities depending on the role that they are undertaking. The need for an identity came out very strongly in the findings as an important strategy to give structure to the lives of the participants and aid cohesion by creating a hidden understanding and a sense of belonging to certain groups within their community, such as their Unit, if serving, or their neighbours or other Regimental wives if not serving.

The psychologists Hogg et al (1995) recognised in their theoretical paper exploring identity theory, that people tend to interact in groups and often adopt the persona of the group of which they are a member, such as 'a wife', 'mother' or 'soldier'. It

explains why one mother wished to be associated with, and so identify with, other serving colleagues until she was on maternity leave. Once on maternity leave both serving mothers wished to be associated with other non-serving wives as they needed the support of the non-serving wives in her neighbourhood to reduce their sense of isolation.

Developing an identity as an "*Army wife"* enabled the non-serving mothers to engage in supporting each other by sharing a common understanding, which in turn helped them to rise to the challenges of Army life. A "*common bond*" was evident not only in how they talked about Army life but also in the cohesion that developed within each focus group, despite the participants being strangers to one another prior to each focus group taking place. The psychiatrists Link and Phelan (2001) pointed out in their theoretical paper on conceptualising stigma, that assigning labels to a group stereotypes its members with the distinct characteristics of that group. This was encapsulated in the study by the term "*Army wife*". This term was used to label the wife of a serving soldier as belonging to a distinct group which displayed certain positive attributes and strength of character, evidenced by being able to handle the pressures of Army life. In addition, it illustrated the mothers' contribution to the Army organisation and that they supported their husband's career. Serving fathers expressed their pride that their own 'wife' was part of this distinct group. While the findings gave the role of an "*Army wife*" a positive identity, the military literature gave examples of Army wives not coping and of suffering from psychiatric disorders as a result (LaGrone 1978; Vincenti 1990; Giles 2005).

Loneliness took two forms for the participants in this study; that which resulted from a loss of nearby friends and extended family because of frequent mobility, and the loneliness caused by the absence of their husband due to military exercises, courses and deployment. Participants talked of the emotional wrench of leaving their friends and the community in which they felt they belonged and "*having to start again*" by attempting to set down roots in their new posting. Mothers talked of being isolated- both from their local civilian community and from their husband during times of military enforced separation. Baumeister and Leary (1995) acknowledged that the loss of one relationship can be replaced by another, but reported that this takes time to develop. During this process feelings of isolation and loneliness may result from the loss of a sense of belonging as the spouse, who acts as the source of their emotional security, is absent, as occurred for the mothers in this study. Dykstra (2009) reviewed the civilian literature regarding

loneliness and confirmed that isolation and loneliness have different meanings, both of which impact on quality of life. She suggested that social isolation is an objective measure of interaction with other people and that loneliness is "*the unpleasant experience that occurs when a person's network of relationships is thought to be deficient in some way*" (Dykstra 2009, p 91). One can conclude from the evidence in this study that it is possible to be lonely without being isolated and vice versa. In this study, the departure and deployment of the husband created a void in emotional support for the mother that no one else could fill, no matter how well mothers had developed close friendships with their neighbours. This explains why these mothers expressed their loneliness despite having close friendships with others in the same situation as themselves; a feature consistent with Giles's (2005) and Dandeker et al's (2006) findings.

The extent of the psychological impact of military enforced separation on the mothers who participated in this study depended on numerous factors, such as the type of deployment, the danger that the husband was exposed too, the mother's levels of fatigue and her sense of identity and belonging with her husband's Unit. Baumeister and Leary (1995) recognised that the death of a spouse or close friend is amongst the most stressful events that one can experience. Even fear of death challenges an individual's sense of belonging as it creates distress because of uncertainty about the future. McCubbin et al (1980) reviewed the US literature to explore coping behaviours within civilian and military US families. McCubbin et al (1980, p 868) concluded that the cohesion of the family as a whole was important when explaining how the family handled stress, as the family was not just a collection of individuals but actually constituted a "*group mind*". This may explain why the mothers felt the loss of their husband so acutely at the beginning of their separation until they had established a new routine without him. This was not just in terms of practical support, "*sharing the burden*", but also emotional support. The data gave clear examples of the emotional stress caused by the husband's absence, such as "*the whole thing's on your shoulders*". This was in addition to their fear that their husband would not return, shown by such comments as "*if he doesn't come back*". For serving mothers, the demands of full-time employment increased their fatigue and subsequent emotional vulnerability further when their child was unwell. The emotional impact of the additional fear for their husband's safety may have meant that they suffered greater fatigue than a civilian lone parent who was working full-time without additional childcare provision.

The data gave a clear indication that military enforced separation took many forms. The extent to which separation challenged the mother's psychological wellbeing depended on the risk and degree of danger to which she perceived her husband was exposed and how fearful she was for his safety. A mother's level of fear was influenced by how easily she could communicate with her deployed husband to reassure herself that he was safe. An increased state of anxiety hindered her ability to problem solve and think rationally and so had a major impact of her decision-making when her child was unwell. Her emotional state influenced what she perceived her options were for accessing a health professional as well as how urgently she sought medical help. The increased levels of anxiety and stress to which these mothers were exposed explain why they were more likely to seek reassurance from a health professional during times of military enforced separation.

Not surprisingly, the most frightening situation for a mother left at home was for her husband to be deployed in a combat role where he was patrolling the streets of Afghanistan with little ability to communicate outside Afghanistan. Ironically, the greater the danger that deployed personnel were exposed too, the more difficult it was for their partners to communicate with them to reassure themselves that he was safe. The participants understood that a communication embargo would take place if an incident had occurred in which a soldier had been fatally or seriously wounded. This was to allow time for the next of kin to be informed, as the Ministry of Defence (2010c) has since confirmed. Parents understood that mobile phones are rarely permitted in the operational environment as they are thought to be a potential distraction that could endanger soldiers who possess them, as the Ministry of Defence (2010a) has highlighted in its document "*The Future Character of Conflict*". Their frustration that their husband's ability to use the satellite telephones for up to 30 minutes a week was dependent on the security situation at the time was compounded by their inability to contact their spouse directly and by their belief that the rest of society took the instant ability to communicate for granted.

At the other end of the spectrum, the least frightening situation for these mothers was when her husband was working in the garrison, exposed to little danger and had free access to all methods of communication. It can be substantiated from the data that the anxiety levels of a wife left at home during deployment increased directly in proportion with the degree of difficulty of communication in terms of:
- Method (via telephone, electronic mail or letter)

- Process (such as a time delay in telephone communication)
- Speed (such as time taken for the post to arrive, which could be days or weeks, or access to electronic mail)
- Quality of communication (such as free flowing conversation without time or security constraints, or fear of creating anxiety for the other spouse)

This finding is not documented in the literature. However, since the study has been completed the Ministry of Defence (2010a) has acknowledged that having a loved one deployed to Afghanistan is particularly frightening for families. This is because the increased use of Improvised Explosive Devices and suicide bombers by the insurgents against Coalition troops has increased the likelihood of serious or fatal injury.

The data confirmed that serving mothers had a greater awareness of the dangers that their deployed husbands were facing because of their personal experience of deployment. As the US military psychiatrists Cozza et al (2005) pointed out in their discussion paper highlighting the paucity of military research into the stress of deployment, media attention gives the next of kin a disproportionate fear that their loved one is likely to be killed. Anxiety and fatigue may have accounted for the fact that only the serving mother recounted incidents of spontaneously bursting into tears in front of strangers during her husband's deployment.

Some mothers found that the operational situation made all communication with their spouse spasmodic, including access to electronic mail. This meant that some mothers communicated via a Freepost Forces airmail letter, known as the 'bluey'. The Ministry of Defence (2009, 2010c) states its desire to ease the stress that limited communication causes the family at home, and acknowledged that even the postal service to Operations is erratic. Supplying airmail letters, and enabling families to post them free of charge, went some way to reassuring the participants that the Army had some awareness of the impact of deployment. Also, that the Army was trying hard to maintain their morale by employing such initiatives as access to 'electronic blueys' and to the 'Storybook soldiers' scheme. The data confirmed that it was not only children who gained great comfort from being able to hear the recorded voice of their father reading a 'Storybook soldiers' story to them, as the mothers also found hearing their husband's recorded voice reassuring. While the Defence News (2007) and Eadie (2010) have reported the benefit of the 'Storybook soldiers' scheme for the children of deployed personnel, the benefit to the parent left at home had not been recognised prior to this study.

The participants found deployment a very frightening time because the high intensity of danger continued for the majority of their husband's deployment, which lasted many months.   However, training exercises created considerable levels of anxiety for the mothers at home also. Fatalities and serious injuries could occur in training exercises also, as their aim is to replicate the reality of deployments. Knowing that their husbands were being exposed to such threats provoked panic, just as an unexpected occurrence creates a sense of grave danger. At the time of the initial fieldwork in 2008, only two fewer soldiers had been killed due to accidents than had been killed due to hostile action in Afghanistan or Iraq (Director General Army Medical Services 2009). Such statistics demonstrate the risks involved in training exercises and illustrate that these mothers were not overreacting by being frightened when their husbands were away training. Despite this, the data confirmed that a lower level of welfare resources are allocated to the welfare departments (such the number of welfare staff and access to transport) during periods when training exercises are taking place. This is substantiated by the Ministry of Defence (2009). This indicates that the Army does not consider training exercises to be as demanding for the family as deployments, even though the practical and emotional impact of military enforced separation upon the family left at home is similar. Also, the media does not give accidental deaths amongst soldiers the same high level of exposure that it does to deaths in hostile action; hence the fear of one participant that her husband "*would die unknown*".

The data confirmed that preparation for deployment, being deployed and recovery from deployment were part of an on-going process, with some personnel preparing for the following deployment before they had finished the recovery phase of the previous one. This finding supported Giles's (2005) and the Ministry of Defence's (2009, 2010c) opinion that British military deployment is a cyclical process which generates a series of different emotions (represented in Figure 2.1.).

The participants acknowledged that frequent mobility and military enforced separation were inevitably entrenched within Army life and that they had no choice or control over when it would take place. This matched Dandeker et al's (2006, p 383) description of the "*non-negotiable*" aspects of Army life. The reality of living with the impact of both separation and the mobility of Army life was not easy. A division of loyalties created emotional conflict within the participants, which in turn, increased their emotional vulnerability and affected their decision-making. As an example, the requirement of serving personnel to fulfil a military commitment in Afghanistan during a time of intense military activity demanded flexibility and

sacrifice for all the family, but this was often at odds with their practical and emotional need for stability and unity.

The findings from this study reflected the emotional turmoil that Morrice et al (1985, p 480) described as *"intermittent husband syndrome"* in their investigation of the impact of separation on the wives of Aberdeen oil field workers while their husbands were away working on the oil rigs. Like wives of Aberdeen oil field workers, the mothers in this study identified themselves as a one-parent family without the financial worry of being single and spoke of their frustration with being married but having to cope alone. The challenges of readjustment to a different routine during reunion and after an operational deployment reported by Army mothers, mirrored the experiences recorded by the wives of the Aberdeen oil field workers when their husbands returned from the oil field.

The more times parents relocated and the longer mothers were separated from their husbands, the more determined they seemed to be to protect their children from the emotional and practical impact of family separation and the "*exigencies of Army life*" that Fernandez-Pol's study (1988, p 418) described. Mothers talked of attempting to fulfil the father's role as well as their own in an attempt to do this. This emphasized the sense of loss that their spouses' absence created.

"Ambiguous loss" was discussed in Section 2.3.2 and described as *"the painful loss that is coupled with a lack of closure" (*Boss (2006, p 251). The mothers in this study had to come to terms with ambiguous loss in many forms. Not knowing whether their husband would survive his deployment, the sense of loss of not having him to share "*the burden*" of childcare, managing their home and making decisions alone all challenged their coping ability. Not knowing whether their husband would live or die created a variety of emotions, from eager anticipation of their husband's return to preparing themselves as a protection mechanism in case "*he doesn't come back*". This reflects the ambiguous loss that Huebner at al (2007) identified that adolescents suffered from (reviewed in Section 2.3.2). Wilson (2008, p 16) commented in his thesis that explored military families' wellbeing that "*Army families have always been characterized by the severe demands placed on them which are not traditional for our civilian counterparts*". It is evident that the sense of loss that this form of separation causes also contributes to making military enforced separation a special case of marital separation. This supports the psychologist Vormbrock's (1993) work, which interpreted parents coping strategies during military separation in light of Bowlby's (1960, 1998) attachment theory.

Vormbrock (1993) described deployment as a very special case of marital separation because of the physical danger to which the absent spouse is exposed in addition to the long duration of separation. She acknowledged that the longer the deployment, the greater the level of distress because of the persistent absence of the secure base (husband) for the parent at home. This led to a greater reliance on others for emotional support. This explains why many of these mothers developed such strong friendships during their husband's absence. Vormbrock (1993) commented that mothers might transfer their need for emotional support onto their children, who are forced into premature adulthood for the period of separation. Certainly, mothers in this study gained a considerable amount of emotional support from their children as they did their best to protect them. One mother reported that she resorted to asking her children for a cuddle when she was upset because of her husband's absence in order to obtain emotional comfort from them, even though her children were under four years old. This seemed to assuage her loneliness to a certain extent, which only her husband could effectively alleviate on his return. One participant acknowledged that she was much more aware and jealous of other couples' demonstrative affection with each other when her husband was away.

The emotional stress that the mothers in this study spoke of so vividly can be interpreted in light of Bowlby's (1960, 1998) attachment theory. Bowlby (1960, 1998) developed his attachment theory with Ainsworth as a framework to ascertain children's responses to physical separation from their mother during attendance at day care nurseries. Bowlby (1960) observed three phases of separation commonly experienced by young children when separated from their mother:
  (1) Protest (related to separation anxiety)
  (2) Despair (related to grief and mourning)
  (3) Denial or detachment (related to defence mechanisms)

Bowlby (1960, 1998) claimed that excessive separation anxiety was due to adverse experiences such as repeated separation or abandonment. Kubler-Ross et al (1972) developed Bowlby's (1960) work to describe the phases of bereavement (denial, anger, bargaining, depression and acceptance) after a death. Bretherton (1992) reviewed both Ainsworth and Bowlby's lifetime work on the conceptualisation of adult relationships in terms of attachment theory. Bretherton, (1992) proposed four phases of adult grief – (1) numbness, (2) yearning and protest, (3) disorganisation and despair, (4) reorganisation. Vormbrock (1993) acknowledged that this explained the anxiety experienced when spouses were separated from each other.

Maslow (1987) recognised in his work regarding hierarchical needs that the desire for safety is a fundamental human need. Maslow (1987) identified that the experience of separation could elicit anxiety similar to the stress experienced by a child on leaving their mother, such as anxious crying and withdrawal. This caused the loss of a sense of safety irrespective of any risk of danger. This accounts for the emotional vulnerability identified in the participants of this study and the military literature. It also reflects the findings of Shipman and Dale's (1999) study, which suggested that being alone increased levels of parental anxiety to such an extent that it reduced civilian parents' ability to cope, making the need to seek help more urgent.

Maslow (1987) pointed out that in the search for emotional security individual adults behave like children, which explains why these parents acted the way that they did. In this study, like children craving protection from their parents, mothers frantically tried to stabilise their emotional world. Many did this by developing rituals as self-protection strategies in the hope that no new challenges would appear. Some never deleted answer phone messages from their husbands during times of deployment in case it was the last record of their voice. Other mothers talked of reverting to childlike behaviour; one spoke of going to bed early to watch television in the security of her bedroom, and another of suddenly became afraid of the dark during her husband's absence when she was the only adult in the house with the children at night. Reviewing the data in light of the military literature (in particular Giles 2005, Huebner et al 2007, Fitzsimons and Krause-Parello 2009 and Davis et al 2011) confirmed that military enforced separation constituted a perceived and actual threat to the emotional wellbeing of these Army mothers left at home and created the feelings of ambiguous loss explored in Section 2.3.2.

5.3 The decision to consult

Out of all the literature reviewed in Chapter 2, there was only one study (a study by Shipman and Dale 1999), that identified that being lone parent without family or friends nearby for support, increased the likelihood of seeking medical advice if their child was unwell. Giles's (2005) and Dandeker et al's (2006) studies conceded that wives faced additional demands and pressure at home because their husband was no longer able to share in the tasks involved with running the household or childcare responsibilities and that this could increase their emotional vulnerability.

The Army mothers in this study found making decisions alone very stressful. Maslow (1987) conjectured that adults crave security from a 'protector' or a

stronger person on whom they can depend. While these mothers spoke of missing their husband's *"voice of reason"*, many of them acknowledged that the mere presence of their husband and the psychological support that he provided enabled them to feel emotionally secure enough to be able to make rational decisions when their child was unwell. This was despite acknowledging that they did not rely on their husband's decision-making ability. This finding was not reflected in the literature except in terms of lone parents being more likely to access health services.

For Army mothers in this study, the increased anxiety during military enforced separation, led to a need for increased reassurance in their decision-making ability, which made the need to seek help more urgent. Mothers found that waiting for the out-of-hours service to call them back caused considerable anxiety, which reflects Campbell et al's (2007) findings. One mother admitted that she had accessed the ED unnecessarily. Anxiety during military enforced separation was exacerbated not because of the geographical distance to the out-of-hours clinic that was discussed in Section 2.4.4, but because of her urgent need to get her child treated as soon as possible so that she would be available to deal with the next crisis that she felt would inevitably come along while her husband was away. This supports the work of Pooley et al (2003), Lattimer et al (2005) and Richards et al (2007) who identified that the parental anxiety created by waiting for a nurse to call back led to an inappropriate use of services. Mothers in this study talked of needing to telephone the out-of-hours service straight away when their husband was absent and of misinterpreting a cold for meningitis. They also spoke of being hypersensitive to their child's symptoms and interpreting them as a looming catastrophe, particularly if they feared meningitis. In this respect, they appeared to undergo a five stage cognitive and emotional process to produce an illness representation similar to that described in Table 2.2. The mother's decision to consult mirrored the civilian literature regarding decision-making, in that a mother's decision whether or not to seek help originated from her own level of stress (Mechanic 1964, Zola 1973, Shaw 1999).

Mothers were more likely to contact the doctor concerning their child's health than their own and reported more illness symptoms in their children when their stress levels were increased such as during times of lone decision-making. The findings from this study verified Zola's (1973) work, by way of statements from mothers who said that they would only seek medical aid for themselves if their own health had deteriorated so much that they were concerned that they might not be well enough

to look after their children. They never called to ease their personal discomfort. for their own benefit if they were unwell themselves. In contrast, reducing their child's distress was one of the main reasons for contacting the out-of-hours service when their child was unwell. In this way, mothers acted as gatekeepers and advocates for their children because their children were too young to make the decision to call health care services themselves. Zola (1973) recognised also that an individual's psychological state or stress level has a major impact on whether they seek or delay seeking medical help for themselves or their children.

Neither the mothers' level of medical knowledge, nor the number of children they had, nor their experience of childhood illnesses, appeared to diminish their degree of panic when they were on their own. For example, a mother of five children and a mother who was a GP both spoke of their fear of misinterpreting childhood rashes and of the need for parental education about childhood illness. While both Grundy-Wheeler (1991) and Crocetti et al (2001) advocated parental education, Hugenholtz et al (2009) highlighted that education and media information campaigns do not dampen parents' fears because they advise parents to seek professional help to avoid missing a serious diagnosis. In addition, doctors themselves often err on the side of caution in such circumstances. Certainly the Department of Health and the Meningitis Awareness Foundation's recent campaign and leaflet stating that "*Meningitis and septicaemia are very dangerous and can kill in hours*" (Meningitis Research Foundation 2009) seem to have panicked rather than reassured the parents that took part in this study.

It was apparent in the data, as in the literature, that a mother's involvement in her child's treatment was restricted to acting on the advice and information that the health professional gave her, rather than being allowed to gather her own information and make up her own mind. This is consistent with the paternalistic decision-making model that Charles et al (1997) described, in which the patient or parent takes a passive role in the decision-making process. It is also consistent with Parsons' (1951) conceptualisation of the sick role.

According to Elwyn et al (1999, 2000; 2001) for decision-making to be 'shared' it must involve at least two contributors, such as the doctor and parent or two parents or a child and parent. Charles et al (1997) reinforced that each party must play an equal part in the decision-making process and share responsibility for all of the decisions made. In January 2011, the Department of Health (2011, pp 3-4) advocated the use of a shared decision-making model in which parents should be

"*in charge*" of making decisions about their child's health and have "*more choice and control*" regarding their child's care. The Department of Health (2010c) concluded that giving parents greater control in decision-making improved health outcomes and increased compliance. Parsons (1951) argued that taking on the sick role carried with it certain obligations and rights for both the patient and the clinician. For example, patients had an obligation to seek expert help and comply with treatment and so took a passive role in the decision-making.

The data confirmed that health professionals dominated the consultation. The only mother who wanted to share the decision-making was a midwife, in which case it could be hypothesized that her status as a health professional may have influenced her interaction with the healthcare providers encountered during the consultation. Mothers' need for reassurance that they had not missed a serious diagnosis and their wish to transfer responsibility to a health professional may have been a factor also. The need to transfer responsibility to a health professional when a parent felt that they could do no more for their child (see Section 4.5.3) is a common theme that is well reported in both the data and within the civilian literature reviewed in Section 2.4.3 (for example Kai 1996a; Kai 1996b; Shipman et al 1997a; Hendry et al 2005).

Concerns about health care provision for Army families have gained considerable media and Government interest during the past two years. This was acknowledged by the Leader of the Opposition (the Right Honourable David Cameron MP) at the time of the fieldwork for Phase Two of the study (Leader of the Opposition's Military Covenant Commission 2008, p 1). Both the NHS in England and the Ministry of Defence have acknowledged that collaborative work needs to be undertaken by the PCTs to resolve the issues regarding access to health care for Army families (NHS Primary Care Commissioning 2011). The previous and present Governments have spoken of remedying the difficulties faced by non-serving members of Army families in registering with a dentist and doctor and have stipulated in their mandates that Army families must not be disadvantaged regarding access to health care because of their frequent mobility (Service Families Task Force 2010; HM Government 2010b). The Ministry of Defence and the NHS Health Partnership Board have set up a working group in response to the Command Paper, "*The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans*" (NHS Primary Care Commissioning 2011). This aims to address the problems relating to NHS access for Army families.

Ease of access had a major impact on whether the participants decided to call the out-of-hours service or not. One mother reported that up to 40 per cent of Army mothers were unable to drive or did not have access to a car within the garrison. While there does not seem to be any literature to support such a high figure, many of the participants spoke of the challenges of gaining access to transport when their husband was away as they could not drive; even obtaining a taxi was difficult. The number of Army mothers who appeared not to be able to drive seemed particularly high compared to national statistics in which only 22 to 28 per cent of those living in rural communities do not own a car (Commission for Rural Communities 2010).

The data supported the findings of Shipman et al (2001) which recognised parents' desire for home visits as they thought it inappropriate to take a sick child out at night. Mothers in this study felt that there was greater justification for a home visit at night during times of separation, as this would avoid disrupting the other children and was a time when access to transport was more difficult. The widespread view that GPs are reluctant to undertake home visits, as reported by Richards et al (2007), was endorsed by the data also. The geographical distance to the nearest out-of-hours clinic and the large number of Army mothers who reportedly could not drive support the concept of "*distance decay*" identified by Lovett et al (2002, p 98) in which rural communities are disadvantaged. This may account for the dramatic decrease of usage of out-of-hours services by Army mothers within the geographical boundary of the study since the change of out-of-hours service provision from the Army to the NHS, which reflects the findings of Campbell et al (2006) and Turnbull et al (2008). Some of the participants without transport articulated that they no longer saw the out-of-hours clinic as an option for care as it was no longer within walking distance.

Mothers with more than one child talked of weighing up the disruption to the other children against the risks of not accessing treatment for their child who was unwell, particularly if this occurred in the middle of the night. Mothers weighed up the likelihood of the illness being self-limiting, the likelihood of being able to treat their child's illness themselves, and the possibility of postponing treatment until they were able to consult their own easily accessible doctor the next working day. On the other hand, they wanted to confirm that they had not missed a serious illness, particularly if they suspected and feared that their child was suffering from a life-threatening illness such as meningitis. These findings are well supported in the literature (such as Kai 1996a, 1996b and Farmer et al 2006). Mothers' expressions

of overwhelming guilt and their sense of being a "*bad mother*" if they missed a diagnosis and did not seek medical aid as urgently as required were not identified in the literature.

Despite the out-of-hours clinic being located further away than the ED, there was no evidence that parents were accessing the ED inappropriately purely because of its geographical location. They were more likely to access the ED for other reasons. For example, some participants believed that their child would be assessed more quickly in the ED than by the out-of-hours services, as they assumed that children were more likely to be "*bumped up*" the queue. If children required urgent admission to hospital from the out-of-hours clinic, data suggested that they would be admitted to the hospital closest to the out-of-hours clinic, which was over an hour's drive away from the garrison, rather than the closest hospital to the garrison which was 18 miles away. This may have influenced a mother's choice of which service she preferred to access.

The study found that parents did not seem to differentiate between health care service provision in working hours compared to the out-of-hours period. They viewed the treatment of their child as a priority, no matter what the time of day or night; however during the night, illnesses and poor health seemed worse. As Shipman et al (2001) highlighted, using the telephone as a mode of consultation was unpopular with parents. The participants expressed their fear of the responsibility of giving correct and sufficient information over the telephone to explain the problem. As Payne et al (2001) acknowledged, parents found that using the telephone as a means of accessing triage placed too great an onus them as service users to give the correct information to the health professional. In addition, they lacked confidence that a health professional could make a correct diagnosis without having seen their child face-to-face.

Mothers viewed that the out-of-hours service was geared towards the treatment of medical conditions such as chest infections, as they assumed the doctor would be able to diagnose their child by listening to any wheezing in their chest. Most saw the ED as appropriate for soft tissue and skeletal injures because of the need for radiological assessment and for potential emergency admission to hospital for their child. As O'Cathain et al (2007) had identified previously, none of the participants in this study seemed aware of Walk-in-Clinics or Minor Assessment Units as an option for care. Such a lack of awareness is supported by other studies (such as Shipman et al 1997a; Rieffe et al 1999; Rajpar et al 2000; Moll van Charante et al

2006) which identified that the majority of patients who had self-referred to the ED had done so because of their potential need for diagnostic facilities or specialist treatment, particularly for musculoskeletal injuries. However, these studies pointed out that patients lacked knowledge of the scope, or even existence, of out-of-hours services. This was not the case for the parents in this study, who spoke of being very familiar with their out-of-hours service provision. All but one mother had accessed it to gain treatment for their child and many had attended a clinic on several occasions.

It was evident from the data that the sight of blood caused a great deal of concern and panic for these parents, so much so that they assumed that if their child was bleeding they should access the ED as an emergency rather than the out-of-hours clinic. The participants' lack of faith in NHS Direct is supported by Rushton (2006), who investigated how nurses from NHS Direct managed risk as part of their decision-making. The participants' conclusion that algorithms were for the security of the nurses by allowing them to ensure that they had not missed a serious diagnosis, rather than for the benefit of patients, was endorsed by Rushton's (2006) findings. Indeed Rushton (2006, p 261) identified that 39 per cent of nurses from NHS Direct had overridden the advice given by the algorithm to a lower level to "*err on the side of caution*" and protect themselves from litigation.

The data in this study confirmed that mothers saw no evidence that the staff from the out-of-hours clinic had acknowledged the considerable decision-making process that they had gone through before contacting them. None of the participants reported being asked about their circumstances, such as whether they were alone or even if they were from an Army family. Mothers' interpreted a lack of questioning about their circumstances as a lack of empathy by the health professionals from the NHS out-of-hours clinic regarding the emotional and practical pressures they were under. They thought that the staff were being dismissive. This increased their anxiety levels further and reinforced their own fears that they were wasting a health professional's time. However, it is not known from the health professional's perspective whether an appreciation of the mother's circumstances needs to be taken into account to treat a sick child effectively. Yet, it is clear from the data that a mother's circumstances play a crucial role, from instigating the call in the first place to potentially affecting the development of the consultation.

No data suggested that Army parents were being consulted about local health provision and amenities, despite statistics confirming that 1500 Army families are registered as patients at the garrison's medical centre, and so a significant portion of the local population. This implies that the local community does not consider Army families to be part of it. It can be hypothesized that LaGrone's (1978, p 1042) "*gypsy phenomenon*" (in which the local civilian community distrusted military families because they were transient which increased feelings of isolation further) exists in British garrisons today. The document *"Equity and Excellence: Liberating the NHS"* (Department of Health 2010c, p 3) stated that health care *"will focus on personalised care that reflects individuals' health and care needs and encourages strong joint arrangements and local partnerships"*. Implementation of this strategy should address the balance to enable Army parents to have their voices heard.

It can be concluded that these parents assessed their level of satisfaction with health services according to the domains defined by Anderson et al (2007). Andersen et al's (2007) domains included parents' assessment of ease of access to care, how the staff from the out-of-hours clinic communicated with them, the staff's demeanour and attitude, the quality of care that they received, continuity of care, the quality of the health care facilities and the interpersonal skills of the administrative and clinical staff.

5.4 How Army life differs from civilian life

The data drew attention to the participants' view that Army life was "*different*" to civilian life and supports LaGrone's (1978) and Morrison's (1981) conclusions that military life had significant features that made it dissimilar to civilian life.

McMenemy (2001) acknowledged in his thesis, which explored why soldiers attended the doctor, that the Army is a distinct subculture of the British society that it defends. It was quite apparent from the data that families of similar rank in this study lived in the same geographical area of the garrison. This indicates that it is a two- tiered hierarchical system of officers and soldiers with little interaction between the two. The Army does not reflect the class structures of the civilian population in which individuals from a variety of backgrounds are encouraged to integrate within the civilian community. Evidence suggests that the "*rigid social hierarchy*" that Fernandez-Pol's study (1988, p 418) described in the US Army in 1988 is still apparent in the British Army in 2011. The "*rigid social hierarchy"* was prevalent in this study, as it was possible to identify the serving person's rank, income and where they were placed within the hierarchical structure of the Army,

simply from a mother's address. This would not be possible from a civilian's address. Nor is an individual's job as likely to have as much of an influence on a family's social life and the neighbourhood in which they live, irrespective of where in the hierarchy of the organisation or company they are placed. However, the social interaction between families of a similar rank was shown to be for practical as well as for cultural reasons. Many non-serving mothers spoke of limited access to transport when their husband was away, making it very difficult to get together with other families who were not within walking distance.

Politicians acknowledged in 2008 that the intensity of fighting against insurgents in Afghanistan was increasing, and that Army families had *"exceptional demands placed upon them"* (Leader of the Opposition's Military Covenant Commission 2008, p 8). This led the Leader of the Opposition (who became Prime Minister in May 2010) to commission a review to explore whether the Military Covenant was being upheld. The review raised awareness within the political arena that meeting the needs of Army families was important (Strachan et al 2010). Once in power the Coalition Government commissioned an independent Task Force to develop innovative ideas to support Army families. This resulted in Strachan et al's (2010) report, which recommended the development of an Armed Forces Community Covenant in which local communities would provide services to support Service personnel and their families.

Allegiance to the Army was demonstrated in many ways. Mothers contributed to the Army as an organisation by their toleration and acceptance of the "*hassles*" of daily life. Participants gave many examples of the sacrifices they had made, such as the amount of time that they could spend together as a family because of the unpredictability of their husband's work schedule. One serving mother was even prepared to sacrifice her husband's presence at the birth of their daughter. Fernandez-Pol (1988, p 418) inferred such "*sacrifices*" of Army families to be as a result of the "*exigencies*" of military life. Enduring many months of military enforced separation, as well as the loss of close friendships and a career of their own, were sacrifices that non-serving mothers had to tolerate, just as Dandeker et al (2006) had identified. Clearly, the non-serving participants demonstrated the courage and forbearance expected of their serving partners. However, demonstrating their allegiance to the Army had its compensations; participants benefitted not only from welfare support, a local support network and friendships with other Army families but also had access to subsidised accommodation and health care of the same standard as the NHS (Ministry of Defence 2008a). However,

these benefits could only be enjoyed while a member of the family (normally the husband and father) remained serving with the Armed Forces, validating LaGrone's (1978 p 1041) term "*extension of the father*".

The 'traditional values' expected by the Army and the Ministry of Defence (2008b) of serving personnel such as selfless commitment, respect for others, courage, forbearance and loyalty were also embedded within the non-serving wives. The data suggests also that these participants make a major contribution to safeguarding the Military Covenant (for descriptions see Army terminology and Section 1.2) by their tolerance of daily disruption, frequent mobility and military enforced separation. All of the participants concluded that living with constant change, upheaval and disruption in their lives would not be accepted as "*normal"* within a civilian environment. Mothers understood that by volunteering to serve in the Army or by marrying someone within it they had to accept its terms and conditions, the "*non-negotiable*" aspects of Army life (Dandeker et al 2006, p 383), challenging though some of these were to accept. However, it may be that accepting them increased their ability to cope and so handle the challenges that they faced.

Parents made constant negative comparisons between the perceived lack of stability in their own lives compared to what they alleged to be the predictable and stable lives of their civilian family and friends. The serving fathers who took part assumed that civilians had greater autonomy with their working day than they did and deduced that civilians "*knock off'* work at five o'clock in the evening as soon as their shift ends. This may be because the only civilian employees with whom they had direct contact were junior civil servants working within their department, who worked their contracted hours and finished at half past four in the afternoon. They may also have been making a direct comparison with their own role in civilian life. For example, one father was a military vehicle mechanic who may have been comparing his working terms and conditions to those of a mechanic for a large car company. Such an employee is likely to 'clock on' and 'clock off' for his shift unless he chooses to work overtime, so is more likely to finish work at the appointed time. Mothers whose husbands were officers gave a different perspective, comparing civilian employment in terms of salary rather than time, and suggested that their husbands would be paid considerably more for their management role as a civilian because of the additional stress of always being at their employer's disposal to work late and to be on call. Such a view of Army life was not reflected in the military literature.

The term *'no man's land'* was another descriptor used by the non-serving mothers, showing that in some respects they lacked a sense of identity.   They could not identify themselves as either "*truly"* military or civilian and were treated as *'different'* by both civilians and the Army. While this term was not used in the military literature reviewed, it is a military term that is most commonly associated with World War One and is used to describe the unoccupied 'neutral ground' between two enemy trenches that neither side wishes to occupy for fear of being attacked by the enemy from the other side (Coleman 2009, p 268). In the context of this study, the non-serving Army mothers perceived that they were in limbo or 'neutral ground'.   Not fully fitting into either the serving or civilian community presented them with a dilemma. In some ways they wished to disassociate themselves from the Army as a self-protection mechanism because of all of the disruption and subsequent heartache it had caused them. However, they wanted also for the Army to treat them as equals to their serving husbands. On one hand they wanted the benefits enjoyed by serving personnel, such as free medical prescription, on the other hand, as they were not serving, they wished to exclude themselves from certain aspects of the Army such as the rank system. They craved empowerment, but equally, they expected the Army to support them by meeting their logistical, psychological and emotional needs. They were angry that as recompense for their toleration of disruption and separation, they were not rewarded with the same level of military dental and medical provision that their serving husbands were afforded, also that they had to "*fight*" to access local health services. Frustration and bewilderment were all the more apparent in the mothers who had recently returned from British Forces Germany, where they had been entitled to access the same military health and dental care as their serving husbands. Parents could not understand why medical and dental provision for Army families should differ depending on where in the world the serving spouse was working. Participants interpreted this as inequity of health care provision and evidence that the Army as an organisation did not value Army families. It confirmed to them that there was a breakdown in the Military Covenant.

In reality, many of the features of Army life that participants interpreted as making Army life "*different"* to civilian life, such as mobility and military enforced separation and the resulting isolation, are not peculiar to Army life but may be experienced by many other populations. Many civilian employees need to relocate to maintain employment or for career progression in the current financial climate of fiscal constraint and redundancy. Many have to work away from home for long periods and so experience employment-related enforced separation, often with

unpredictable working hours. Also, civilian groups do not benefit from a well-established welfare department to support the families of employees. However, few civilian wives have to live with the constant fear of "*waiting for the call not to come*" to inform them that their husband has been fatally or seriously injured.

5.5 Summary of chapter

This chapter has explored the coping strategies that mothers developed and used in order to help them handle the practical and emotional challenges that they faced as part of Army life, particularly when their child was unwell during times of deployment. It has given theoretical explanations to explain why identity, a sense of belonging and an ability to trust were such important strategies to enhance an Army mother's ability to cope.

Viewing an Army mother's coping strategy in terms of Leventhal et al's (1967; 1983; 1998) and Lazarus's (2006) belief that coping strategies are either emotion-focused or problem-focused provides the key to explain why mothers put the strategies in place to reduce their emotional vulnerability. Understanding Maslow's (1987) theory that a sense of safety is a fundamental human need explained why fear for their husband's wellbeing challenged the mothers' sense of safety to such an extent that it created a state of turmoil and panic which altered their decision-making behaviour, particularly during times of deployment. This explains why it was so important to develop group conformity as an *"Army wife*" and a "*common bond*", a sense of identity and belonging with their local military community, irrespective of whether that community was their husbands' Regiment or the road in which their military housing was located.

Clearly Army life is "*different*" to civilian life. Both the military literature and the data imply that "*Military Family Syndrome*" as described by LaGrone (1978, p 1041) exists in the British Army today as much as it did in the US Army in 1978. However, both the military literature and the data suggest that the perceived differences between military and civilian life are not related to the participants' assumption that the civilian work ethic is to "*knock off*" as soon as their scheduled working hours are complete. The key differences between military and civilian life is that military families face many stressors at once and are often living with constant fear for their loved one's safety. Military enforced separation creates ambiguous loss while constant disruption and an inability to plan in an integral part of their daily lives.

Exploring the data in light of both empirical studies and the theoretical literature has led to a greater insight into the adaptive problem and emotional-focused coping strategies used by Army mothers. This insight confirms that Carver and Connor-Smith's (2010, p 685) definition of coping as *"efforts to prevent or diminish threat, harm and loss, or to reduce associated stress"* is appropriate in the context of this study.

The next and final chapter of this thesis draws on the arguments presented in this chapter as it evaluates the study, makes recommendations and suggests priorities for future research.

Chapter 6 Conclusions and Recommendations

6.1 Introduction

This final chapter draws conclusions by way of evaluating the study including its strengths and weaknesses. It considers the implications of this research on future policy for out-of-hours care for Army parents. It concludes with suggestions for key areas of future research.

This study has explored the impact of Army life on parents with dependant children. In doing so, it has provided a detailed description of the reality of being an Army parent in the present operational climate. It has explored the impact of Army life on the decisions that mothers within an Army garrison make when their child is unwell. Its additional strength lies in its connection to the limited body of knowledge identified in the literature (reviewed in Chapter 2) within today's current political and military environment. The links to concepts such as belonging and loss and the theory of coping, previously discussed in Chapter 5, are also highly relevant. It fills a gap in knowledge regarding a mother's decision-making behaviour and her expectations for care when her child is unwell, particularly when a lone parent

This study was undertaken in the political and social context of the military campaigns in Afghanistan and Iraq. The findings have provided a rich description about what Army life is like and in doing so, has clarified the *"exceptional demands"* that Army parents face (Leader of the Opposition's Military Covenant Commission 2008, p 8), particularly during times of military enforced separation. It illustrates the impact of Army life during any period of military enforced separation, regardless of the characteristics of the deployment and the coping strategies required. It gives insight into the help-seeking behaviour of any civilian mother undergoing enforced separation from her partner or when making decisions about the care of a sick child on her own. Many of the findings of this study will resonate with other Service families and those caring for and supporting them, irrespective of the time (2008 and 2010) that the fieldwork was undertaken and the garrison in which this study took place.

The findings recognised that daily disruption, frequent mobility and military enforced separation are features that affect the daily lives of Army parents. They have demonstrated that the mother's fear for her husband's safety, combined with fatigue during times of separation, increased her emotional vulnerability. Her level

of fear was directly in proportion to her perception of the danger that her husband was exposed to and how easily she could communicate with him to reassure herself that he was safe. Fear for the husband's safety was felt regardless of whether the serving spouse was on a live firing training exercise or deployment.

The anxiety and fear generated during military enforced separation increased the mothers' feelings of emotional vulnerability to such an extent that it influenced whether they sought the advice of a health professional as a first or last resort (Figure 4.1 in Chapter 4). This was markedly evident in the findings from Phase Three of the study, as the fieldwork occurred during the time that '*Operation Moshtarak*' took place, a particularly intensive campaign in Afghanistan (International Council on Security and Development 2010). Many of the participants' friends and family were deployed and taking part in this campaign during the time that the fieldwork took place. Army mothers sought professional help as a first resort in their husband's absence. This was as a result of a sense of panic and fatigue caused by fear for the husband's safety, as well as the responsibility of not having the husband at home to share the "*burden*" of childcare and household organisation. If her husband was present to assist with the decision-making, she called the out-of-hours service only once all other sources of advice had been exhausted. However, the husband's mere presence or absence was the key feature, not his decision-making ability. The impact of such stress made all the participants extremely protective of their children, both from any suffering caused by being unwell and from the impact of what Dandeker et al (2006, p 383) called the "*non-negotiable demands of the military*".

The findings from this study support that LaGrone's (1978, p 1041) "*Military Family Syndrome*", Morrice et al's (1985, p 480) "*intermittent husband syndrome*", Vincenti's (1990, p 78) "*peculiarities of Army life*" and Dandeker et al's (2006, p 383) "*non-negotiable demands of the military*" all exist in the lives of Army parents in the military climate of the 21st century. Exploring the origin of these terms, from as long ago as 1978, shows the importance of reviewing the military literature from many decades and demonstrates that fundamentally the impact of Army life has changed very little over the decades. However, what has changed, even over the course of this study, is an increased use of Improvised Explosive Devices and suicide bombers by the insurgents against coalition troops in Afghanistan during the present global campaign against terrorist activities (Ministry of Defence 2010a). As a consequence of the rise in the intensity of military action, an increasing number of serving personnel from the garrison in which the study took place were

deploying and being exposed to a high risk of being seriously or fatally injured. The data verified that the level of fear and anxiety that Army mothers are experiencing has increased as a direct result of their friends and family deploying. The study findings showed the importance of belongingness and loneliness as key predictors of psychological wellbeing. Investigating the concepts of belonging, loneliness and loss, explored by Baumeister and Leary (1995), Mellor et al (2008) and Boss (1999, 2004, 2006, 2007) has helped to explain why the husband's absence had such an impact on the mother's decision-making when her child was unwell. As Maslow (1987) pointed out, it confirmed also that the desire for safety is a fundamental human need. Participants in this study used certain strategies to boost their sense of belonging by creating an identity as an "*Army wife*". They developed coping strategies that were either emotion-focused or problem-focused to reduce their emotional vulnerability. For example, engaging in activities with their neighbours was an emotion-focused coping strategy to reduce their sense of isolation and loneliness. While this study was undertaken within an Army environment, it gives insight into how a mother's psychological state affects her decision-making when her child is unwell, particularly when alone, that is widely applicable to other populations.

Many studies in the literature, such as Shipman and Dale (1999), confirmed that having a child who is unwell during the out-of-hours period is a stressful situation in its own right. It was substantiated in the data that military enforced separation challenges a mother's sense of belonging and safety because of fear for her husband's well-being, which increases her anxiety and feelings of emotional vulnerability. Each of these scenarios (having a sick child or undergoing military enforced separation) could be viewed as a 'magnifier' as their impact is enlarged, amplified or increased in certain circumstances. Having to care for a sick child at the same time as being fearful for her husband's safety means a mother faces both 'magnifiers' at the same time. The additional stress causes by this combination of 'magnifiers' impacts on her ability to make rational decisions when her child is unwell.

As with other civilian studies (for example Houston and Pickering 2000; Richards et al 2007), the mothers that took part in this study did not take the decision to call the out-of-hours service lightly and wished to be taken seriously (Richards et al 2007). This study confirms the evidence in the literature that mothers are the principal carers of their children, irrespective of whether maintaining a career, supported by a partner or as a lone parent. Many of the features of Army life that

parents concluded made them "*different*" from civilian communities, such as frequent mobility, are common in civilian communities also. However, it is the accumulation of having to handle so many of life's major stressors at once that makes the life of an Army mother "*different*". For example, a civilian lone parent may have the advantage of living near extended family, possess a long-standing established network of friends for support, and not fear sudden bereavement as acutely.

This study has given insight into the particular context and life of an Army parent as a lone parent. Nevertheless, such a paucity of evidence in the literature regarding lone parent decision-making has meant that this study has filled an important gap in understanding of the decision-making process of mothers during times as a lone parent; particularly when they are anxious and fearful for a loved one's safety.

Army parents expected the Army to uphold the Military Covenant by providing them with appropriate health care and logistical support as amelioration for the disruption that the Army caused them. Also, they expected to be treated with empathy by health professionals who understood their circumstances and the challenges that Army families face. The findings from this study provide a vital insight into Army life and parental decision-making. The insight gained from this study can be used by local communities to increase their understanding of the complexities and demands of Army life so that they are better equipped to address the health needs of Army families.

This research has taken place at a crucial time for both the Army and for the policy of contracting out out-of-hours service provision for Army families. Since the study was completed, the Coalition Government has come into power and demonstrated its commitment to supporting Army families by commissioning an independent Task Force to develop innovative ideas to support Army families. This resulted in Strachan et al's (2010) report that recommended the development of the Military Covenant into an Armed Forces Community Covenant, in which local communities are to provide services to support Service personnel and their families.

6.2 Evaluation of the study

A constructivist viewpoint lent itself to an in-depth qualitative case study within the social setting of an Army garrison. It facilitated the exploration of a phenomenon of Army life within that setting, so that the decision-making of Army mothers could

be explored in detail. This supported Stake's (1995; 2000; 2008) philosophical beliefs of a constructivist interpretation of case study rather than Yin's (2009) more positivistic approach. Divorcing the cultural and social military context from this study would have made it impossible to explore in sufficient depth the decision-making of Army mothers. This is because Army life proved to have such an influence on the decisions that mothers made. Using more than one method of data collection (focus groups and interviews) provided greater insight and enabled the research questions to be answered more effectively than if only one method had been used.

This study was undertaken at a particular time and place and within a certain context. While purposive sampling entails the use of *"key informants"* to maximise an understanding of the phenomenon (Kitzinger 2006, p 24), it relies on the self-selection of the participants who opt to take part. As participation was voluntary, it is possible that those who took part did so because they wanted to highlight particular issues about Army life or access to health care during the out-of-hours period. However, there was no evidence that the findings were reporting an extreme or distorted view of Army life or out-of-hours care. Also, none of the focus group participants attempted to suppress others from expressing their views or dominated the discussion to the detriment of other participants.

As Booth et al (2007) and the Ministry of Defence (2008a) pointed out, there is great diversity in types of Army families. These include single parent families, dual career families, reconstituted relationships with step-parents or children and an increasing number of Army families in which both parents are serving, all of whom should be represented in military research as well as parents from many different cultures. However in this study, (and in many others, such as Fernandez-Pol 1988; Ryan-Wenger 2002; Giles 2005; Davis et al 2011) those who volunteered to take part were mainly non-serving Army mothers who did not work full-time, so the findings were primarily from their viewpoint. This may have put limitations on the study findings. Despite this possible limitation, the willingness of serving fathers to participate and ensure that their views were represented broadened the perspective given and demonstrated serving personnel's commitment to the study.

One can only hypothesize why non-serving mothers who were working full time did not volunteer to participate in the study. The disruption and mobility of Army life may have prevented many mothers maintaining a career and working full time. The

few that are fully employed may have assumed that they would be required to participate during their working day, even though this was not the case.

My own military experience in combination with my appraisal of the literature enabled me to identity the gaps in knowledge and questions that had yet to be answered. The Surgeon General's Research Compendium for 2010 (Surgeon General Department 2010) confirmed that this study is the only research project within the Defence Medical Services to include service families in its study population. All other military research is focused on improving medical treatment for soldiers in combat. The lack of research exploring issues that are important for Army families during the current high level of Operational intensity has raised the importance of this study considerably. This is particularly true in light of Strachan et al's (2010) report *"Report of the Task Force of the Military Covenant"* in which it is recognised that supporting the family increases the morale of the soldier and so his operational effectiveness.

6.2.1 Recruitment for further military studies

This study demonstrated that recruitment for military research studies can be problematic and mirrors the difficulties recognised in other studies (such as Fernandez-Pol 1988; Ryan-Wenger 2002; Giles 2005; Dandeker et al 2006; Huebner et al 2007). Attendance at places where Army parents socialised was vital in order to raise the profile of the study and to give the participants confidence that I was committed to hearing their views. Using Unit Welfare Officers and Army nurses from the garrison's medical centre as facilitators proved essential to ensure that adequate numbers of 'key informants' were recruited to the study and also avoided issues of coercion. It is recommended that individuals who know the study population well, such as Army nurses or Unit Welfare Officers, should be used as recruiters for all qualitative military studies so that 'key informants' can be targeted. The poor response to postal recruitment demonstrates that recruitment is best undertaken using a face-to-face approach rather than by post.

The mobility of the study population meant that two potential participants had to withdraw from the study because they had relocated between the time of recruitment and the fieldwork taking place. The mobility of Army families necessitates that fieldwork must take place as soon as possible after recruitment because of the risk that some potential participants relocate before they have had the opportunity to take part.

6.3 Reflexivity

The fact that I am an Army mother, wife and officer is bound to have had an effect on the study. I chose to investigate parental decision-making because of my experience, knowledge and belief that it was both worthy of study and that there were ways in which a deeper understanding could help to improve the care for and support to Army parents in this context. Nevertheless, my various roles may have influenced the way participants reacted towards me. For example, they may have made some assumptions about me and of my knowledge of Army life because of my military experience. It is possible that they omitted to raise particular issues that they would have explained to a civilian who had a limited knowledge of Army life. I mitigated this limitation by asking them to talk to me as if I knew nothing about the Army. Additionally, I ensured that an experienced civilian research fellow from the university, who had no knowledge of the Army, acted as the scribe in the focus groups for Phase One so that I could glean perceptions of Army life from a complete outsider.

I was aware of my own inevitable biases, both in terms of the choices I made (for example, the kinds of data to be collected) and the way in which I analysed and interpreted the findings. In doing so I have attempted to achieve trustworthiness, dependability, credibility and transparency by giving an explicit account of my key decisions and by keeping my analysis grounded in the empirical data. In a very practical way, taking field notes throughout has helped me to prevent my own views and experiences from overly influencing the study. In addition, my civilian university supervisors have read my transcripts, coded two transcripts independently and critiqued my analysis at each stage. Remaining reflexive has been paramount whilst undertaking all of these processes.

During the study, I have been aware that I am likely to deploy to Afghanistan soon. Hearing the distress of the participants and the extent of their determination to protect their children from the impact of Army life was very powerful for me and made me reflect upon my own circumstances. As I was writing about the impact of separation in the discussion chapter of this thesis, I was a lone parent undergoing military enforced separation myself while my husband was undertaking a training course. As Stake (2000) suggested, this insight enhanced an exploration of alternative interpretations to convey the context, emotion and uniqueness of the case to enable the reader to enter the world of the Army parent. My analysis was intellectually better as a result.

6.4 Recommendations

It is possible to make recommendations that have utility for both the Army and the NHS out-of-hours providers from the findings and conclusions of this study. Recommendations are made in terms of the issues that the Army Primary Health Care Service (APHCS) should consider to ensure that it commissions appropriate, out-of-hours service provision for Army families. Recommendations are made that are pertinent to NHS service providers and the health professionals that care for Army families. However, it is appreciated that commissioning out-of-hours services occurs at a time of close financial scrutiny by both the Ministry of Defence and the Department of Health

6.4.1 The Army

Commissioning services

The findings of this study have demonstrated that Army mothers are more likely to access the out-of-hours clinic during military enforced separation when their husband is not present to assist them in their decision-making (see Figure 4.1 in Chapter 4). Some of the findings such as the expectation for a local out-of-hours service within walking distance, face-to-face contact and home visits are common expectations in the general population as Farmer et al (2003) pointed out. This is particularly the case for rural communities who can feel isolated and disadvantaged compared to their urban counterparts. However, the unique circumstances of Army parents, particularly during times of deployment, justify that APHCS should consider these expectations when it commissions out-of-hours services for Army families. It is appropriate to assess the distances to local out-of-hours service provision during commissioning of services, as it appears that so many mothers do not drive. This would ensure that the out-of-hours clinic is situated at an appropriate distance from the garrison where Army parents are living and working or alternatively, that freely accessible transport is available at all times, particularly at night when mothers are at their most anxious.

The participants in this study commented that they did not feel that NHS staff always understood the pressures of Army life to which they were subjected. The rich description of Army life given in this thesis could be used by APHCS to develop a pamphlet for NHS providers who have limited experience or knowledge of Army life. This would give NHS staff a vivid account of the reality of being an Army parent in the current political and military climate. The algorithm in Figures 4.1 in Chapter 4 illustrates that the husband's presence and absence affects the decisions that mothers make when their child is unwell. This algorithm could be adapted to

alert out-of-hours providers to the possibility that Army mothers may be emotionally vulnerable when they call the out-of-hours service and may have additional or different psychological needs to the civilian population as a result.

It is appreciated that out-of-hours providers may not have the capacity to provide sufficient psychological support to meet the need for reassurance that Army mothers require when they are at their most emotionally vulnerable. This is particularly true during times of deployment, irrespective of how minor their child's illness or injury is. APHCS policy makers are encouraged to investigate whether a military medical telephone helpline should be instigated to provide mothers with immediate access to telephone advice for reassurance, and to signpost them to further health services to avoid them having to wait for a health professional to telephone them back.

The Army as an organisation
The organisation of training exercises during school holidays caused much frustration amongst these parents, particularly as they often occurred at short notice so that family plans had to be changed. It is appreciated that the timing of such events may be beyond the Army's control and may be inevitable in light of the current political unrest in the Middle East; however, giving as much notice as possible might increase acceptance by the families affected. Parents may benefit from being kept informed of the Government's objectives and their priority for completion so that they understand why, how, when and what tasks needs to be undertaken. This may lead to a reduction in the levels of frustration if plans need to be altered at the last minute.

In 2009, the Ministry of Defence (2009) confirmed that the comprehensiveness of the Army's welfare package for families is dependent on the deployment status of the Unit. This permits more extensive provision at times of deployment than during training exercises, even if the training is of several months duration abroad. However, the data highlighted that the practical impact of separation was the same irrespective of the cause of separation, loss of transport when their husband was not available able to drive them is an example. The findings also demonstrated that often Army parents do not live close to extended family and friends who are able to provide practical and psychological support. As a result, the logistical and emotional support that Unit Welfare Officers provide to their families is very important. Since the study has taken place, the Government has demonstrated its determination to continue the provision of suitable welfare packages for Army families as part of its commitment to upholding the Military Covenant in its latest

Strategic Defence and Security Review (Ministry of Defence 2011e). To ensure that the Government meets the welfare need of Army parents, it is recommended that welfare provision is equitable and available during any form of military enforced separation of any duration regardless of the cause, particularly as many Army wives and mothers do not drive. This support needs to be consistent throughout the Army irrespective of Regimental or Corps status.

These participants expressed confusion as to the disparity in health provision for Army families between the UK and abroad. Therefore, health care should be equitable, responsive and accessible for all Army families, irrespective of their serving status and global location. APHCS and Unit welfare departments are encouraged to continue to promote a close working relationship to ensure that all Army mothers have equity of access to health care during times of military enforced separation, regardless whether they have available transport or are from a Regiment or a Corps.

Mothers identified that an allocation of 30 minutes free call time a week during deployment was such a short time that it lowered their morale, particularly as this was only equivalent to a prisoner's allocation. Also, the time allocated was too short to allow deployed personnel to communicate meaningfully with family members. It is suggested that the present allocated time of 30 minutes per week is increased to contribute to a reduction in deployment-related stress. However, it is appreciated that this must be within the constraints of the challenges of communication in the operational environment such as Afghanistan.

Mothers reported a cathartic benefit from taking part in this study. This highlights the need for Army parents to have a facility where they are able to talk openly to a third party in total confidence, who will listen to them without judgement. Getting together with other mothers in a similar situation in order to develop a confidential self-help group to support each other might be helpful, as it is appreciated that mothers did not want to burden their friends or family with their concerns. The Ministry of Defence (2009) confirmed that the Army offers a free confidential telephone helpline for Army families in its *Guide for Families of deployed Regular Army Personnel*. This guide must be widely publicized as none of the participants during the fieldwork in 2010 seemed to be aware of its existence or of a confidential telephone helpline. The Army should continue to consider ways of allowing and supporting Army mothers to express their fears and anxieties,

particularly during times of separation, by facilitating a forum to enable them to talk face-to-face and openly to an impartial individual whom they trust.

The Army should continue to provide as much information as is feasible about the new location for the family before they relocate so that the family have realistic expectations of their new location. Some of the data regarding the impact of military enforced separation would be useful to incorporate in the pre-deployment information pack given to Army families, as this may reduce some of the feelings of emotional isolation identified by the study participants.

6.4.2 Out-of-hours service providers

The NHS Commission is aware that all PCTs in England should acknowledge the particular problems that Army families may face regarding accessing NHS care. This is because to the civilian community Army families are "*invisible forces families*" and may be accessing NHS care anywhere in the country (NHS Primary Care Commissioning 2011). Indeed a map depicting the location of Army families within PCTs confirms that although the majority of Army families are located within certain geographical areas, every PCT within the UK has Army families living within its boundaries (Defence Analytical Services Agency 2008b).

Healy and McKee (2004) acknowledged in their book *Accessing Health Care Responding to Diversity* that policy makers have a responsibility to be responsive to the diverse needs of the population of their country. The Department of Health (2010b) encourages commissioners and providers of health care to seek and respond to the views of patients and the public and to incorporate these views into their strategies and service development. Chandra et al[1] (2010) and Ternus (2010) recommend in their recent research (published since this study was completed) that health care providers need to be sensitive to the life-changing experiences that their patients might be undergoing as part of the holistic care that they should be providing. Mothers would benefit from out-of-hours service providers demonstrating awareness that the assessment of the mother's psychological and emotional state is an important part of the consultation. This is in order to provide effective and satisfactory medical treatment for the child who is unwell as the personal circumstances of the child's mother impact on the whole consultation. This insight could be demonstrated by asking every mother whether she is

---

[1] Chandra et al[1] (2010) explored the experience of children from military families. Mona (2010) explored the support for adolescents who experience parental military deployment.

supported or alone at the first point of contact with the out-of-hours service; irrespective of whether or not she informs the call handler that she is part of an Army family. The call handler or health professional can then establish whether she is likely to be calling as a first or last resort which should demonstrate to Army mothers that the out of hours service understands that military enforced separation impacts on the parent left at home.

6.5 Key areas for future research

It was evident from both the literature reviewed and the findings that the father's perspective is not well represented. The percentage of women serving in the Army has doubled in the last 9 years from just over five per cent of the Army in 1990 to just under ten per cent by 1 October 2009 (Ministry of Defence 2010d). Around 8,000 British troops are currently serving in Afghanistan, 20 per cent of whom are female, many of whom are mothers (Defence Analytical Services Agency 2011b). The increasing number of women that remain serving once they become parents suggests that a greater percentage of serving mothers will be deploying in the future, and so leaving the father at home as the principal carer. Future studies should be undertaken to identify the impact of deployment and military enforced separation on the father left at home.

The findings in this study have demonstrated that families of Corps personnel are not part of a Regimental cohesive group that relocates en masse and tends to stay static in one location for many years. They appear to have less consistent welfare provision from their Unit Welfare Officer than Regimental families. Further research is needed to confirm whether the greater mobility of mothers whose husbands are serving with a Corps means that they need additional or different emotional support when their child is unwell than those from Regimental families. Gaining the perspective of the Unit Welfare Officers might shed light upon whether this is the case. Data are required to substantiate the assumption made by one participant that 40 per cent of Army mothers do not drive. This would identify the level of logistical support that may be needed during times of military enforced separation as part of the Army's duty of care to its families.

Undertaking a similar study as this with families from the Territorial Army may give insight into the impact of deployment from a different perspective, particularly in terms of the fear and vulnerability they feel. On the one hand, it is possible that these families would be established within their local civilian community with an existing network so that separation would not make them feel so isolated. On the

other hand, they may not have the support of other Army families around them who understand the pressures that they are under and so they may not be able to benefit from "*the common bond*" that the regular Army participants identified. Leach et al (1993) concluded that parents might access health care for psychological support for themselves as much as for their sick child with those mothers who presented their child frequently to their GP having a higher level of psychological stress. In the light of the present military commitment to overseas missions, which shows no signs of abating, research needs to be undertaken to investigate in greater detail the relationship between the severity of the psychological distress of Army mothers and attendance rates with a health professional. The difference in attendance rates depending on whether or not the mother is undergoing military enforced separation could also be investigated. Also, further research needs to be undertaken to explore the consequences of separation on the mental health of Army parents in the longer term.

Further exploration of decision-making could compare the decisions made by Army mothers who have attended the NHS out-of-hours clinic a driving distance away as exemplified in this study, with those of mothers whose NHS out-of-hours clinic is located within walking distance, as occurs in another Army garrison in the UK. Mothers may give a different perspective of the factors involved in the decisions they make depending on the impact of 'distance decay' (Vedsted et al 2001b; Campbell et al 2006). The level of understanding that NHS health professionals have of Army life warrants detailed investigation also.

6.6 Conclusions to the study

The insight that this study provides into an Army mother's help-seeking behaviour can be applied to any civilian mother undergoing prolonged enforced separation from her partner and when making decisions alone, such as the partners of prisoners or those who work away from home such as oil riggers. Equally, it can be applied to all families within organisations who undergo unaccompanied postings to places of danger, such as the other Services (the Royal Navy and the Royal Air Force), North Atlantic Treaty Organisation (NATO), United Nations and Foreign and Commonwealth Office. However, 'the magnifiers' may be different in each context and so affect the mother left at home in different ways. This in turn may have a greater or lesser impact on her ability to make rational decisions when her child is unwell.

Strachan et al's (2010) *Report of the Task Force of the Military Covenant* has recommended that local communities should develop a strategy for providing services appropriate to the Service personnel and their families that live in their area. Therefore, out-of-hours providers must be aware that many of their patients may be part of an Army family, even if they do not identify themselves as such.

Daily news bulletins report the deaths of soldiers deployed in the present military campaign against insurgents in Afghanistan, with no signs of this stopping in the near future. Previous history and Defence policy dictates that the Army will continue to play a major role in countering threats to our national security abroad and at home and be involved in overseas conflicts in which soldiers risk being seriously or fatally wounded (Ministry of Defence 2010a). As a result, Army families will continue to experience daily disruption and undergo military enforced separation, and therefore they are likely to continue to experience the fear that this entails and that is described so vividly in the findings of this study. The circumstances of Army parents, particularly the impact of deployment, must be taken into account when commissioning health services for Army families. Out-of-hours service providers have a responsibility to ensure the care they provide meets the needs of Army families as they are a part of their local population. As Chandra et el (2010) discussed, NHS health providers did not need to be aware of Army families in the past, as the Army as an organisation was self-sufficient in that it provided its own health care independent of the NHS and Army families were detached from civilian communities behind wire fences. Nowadays Army families integrate fully with their local community members of which may not be aware that they are an Army family at all.

This study provides vital insight into the decision-making of Army mothers when their child is unwell, particularly during times of military enforced separation. It identifies the psychological, emotional and logistical support that mothers require to reduce their emotional vulnerability. As this study has shown, being alone has a major impact on when a mother decides to access health services. The algorithm (developed from the findings and depicted in Figure 4.1 in Chapter 4) demonstrates the impact that a partner's presence or absence has on a mother's decision to access health services when her child is unwell. Dissemination of the algorithm to NHS providers may help NHS health professionals who are caring for Army families to gain an insight into the decision-making process that a mother might have undergone prior to calling them. Viewing the flow chart within the algorithm illustrates why it is important to identify whether the mother has made her decision

to access health services on her own or with a partner and that this can influence the entire consultation.

Many other populations may undergo the isolation, loneliness, fear and vulnerability experienced by the mothers in this study. Asylum seekers, refugees and the families of prisoners are examples of populations that may undergo frequent mobility or enforced separation from their loved ones. Consequently, the findings from this study may give insight into the help-seeking behaviour and decision-making of mothers in other populations and prove useful to health providers caring for parents far beyond the group of Army parents from the garrison in which this study took place.

Changes in both health and defence policy are likely to have major implications for the commission and provision of out-of-hours care over the next few years. Since this study has been completed, the Government has laid out its vision for the NHS in the policy document "*Equity and Excellence: Liberating the NHS*" (Department of Health 2010c). In light of the present fiscal deficit and growing national debt, this policy document presents major changes in the way future services are to be commissioned. PCTs in England will cease to exist in 2013 when GPs and practice teams will become responsible for commissioning services through the Commissioning Consortia; an independent and accountable NHS commissioning board will allocate and account for NHS resources (Royal College of General Practitioners 2011). The Royal College of General Practitioners Centre for Commissioning Competency Framework (2011) believes that health care commissioning should be based upon improving outcomes, patient empowerment and putting the needs of communities first (Royal College of General Practitioners 2011). This is an ideal time to raise the profile of the needs of Army families as the Army commissions its health service provision. The Government has stressed its commitment to improving access to primary care in "*disadvantaged areas*". It has emphasized its commitment to "*improvement in health care outcomes as the central purpose of the NHS*" and to ensure "*a more responsive, patient-centred NHS, which achieves outcomes that are among the best in the world*" (Department of Health 2010a, p 48).

In addition to the Government's new strategy for the NHS, the Strategic Defence and Security Review (SDSR) directs the future shape and role of the Armed Forces in light of its mission to maintain British stability "*to deliver the priorities identified in the National Security Strategy*" (HM Government 2010a, p 4). The Ministry of

Defence must make difficult decisions on how it is to finance health services for Army families in light of the Government's requirement to tackle a £38bn deficit in the defence budget that has accumulated in the 12 years since the last Defence Review (Ministry of Defence 2011d).

Undertaking this research has been particularly important in the current political climate in which the care of Service personnel and their families is receiving intense media interest. According to recent statistics from the Defence Analytical Services and Advice (2010), the number of deaths and serious injuries of those deploying in the military operations in Iraq and Afghanistan during the course of this study is far higher than in previous recent conflicts such as the Balkans. The Army has a duty of care to both those it has recruited and to their families as part of its role in the Military Covenant (Ministry of Defence 2007, Strachan et al 2010). In 2004 APHCS highlighted its responsibility to provide safe and effective primary health care provision for Army personnel and their families within the UK (Ministry of Defence 2004). This is as strong as ever in 2011, despite the financial restraints placed upon the Army Medical Services following the Strategic Defence and Security Review (Ministry of Defence 2011e).

In summary, this study has generated new knowledge concerning what Army life is like for Army parents and its impact on the help-seeking behaviour of Army mothers when their child is unwell, irrespective of their serving status and the coping strategies that mothers used. I have argued that there is an inextricable link between the impact of Army life and mothers' decision-making and that the husband's presence or absence has a major impact on the decisions that Army mothers make when their child is unwell during the out-of-hours period. In particular, I have theorised that the anxiety and fear experienced during military enforced separation challenges a mother's fundamental need for safety and belonging. Her increased emotional vulnerability intensifies her need for reassurance and affects her decision-making ability when her child is unwell during the out-of-hours period. Thus, this thesis makes an important contribution to the development of both civilian and military knowledge regarding a mother's decision-making behaviour and her expectations for care when her child is unwell, particularly when she is a lone parent.

Appendices

Appendix 1 Websites, bibliographic databases and search terms

Appendix 1.1 Examples of websites searched

Examples of websites searched
National Library for Heath (NLH) Cochrane Library to access:
• Bandolier
• Cochrane Database of Systematic Reviews (CDSR)
• Database of Abstracts of Reviews of Effectiveness (DARE)
• Health Technology Assessment Database
• NHS Economic Evaluation Database
• The Centre for Evidence-Based Medicine
• Cochrane Collaborative website
National Centre for Health Statistics
NHS The Information Centre e.g to access NHS Evidence - Commissioning
Social Sciences Citation Index e.g. ISI Web of Science
Google Scholar™
Military websites e.g. www.Armynet.mod.uk
Health websites e.g. Department of Health; NHS in England;
Research Service Delivery and Organisation Programme (SDO)
House of Commons Parliamentary Papers

Appendix 1.2 Example of bibliographic databases searched

Examples of bibliographic databases searched
MEDLINE (1950-2011)
Cumulative Index to Nursing and Allied Health Literature (CINAHL) (1982-2011)
British Nursing Index (1985-2011)
EMBASE (1974-2011)
Health Management Information Consortium (HMIC) (1979-2011)
Allied and Complimentary Medicine (1985–2011)
DH DATA (1983-2011)
PsycINFO (1980- 2011)

Appendix 1.3 Examples of search terms used

Search terms[1]
Army; military; military medicine; military personnel
attitude; attitude-to-health; attitudes; child;
expectations; satisfaction; acceptance of healthcare; acceptance of health care; patient acceptance of healthcare
families; family; parents; mothers; spouses; dependents; dependants; lone parents
family practice; general practice; general practitioner; general-practice; general-practitioners; primary healthcare; primary health care
health facilities; health service; health services; health-provision; health-service; health-services; health-services accessibility
accessibility; health needs; health-needs; access;; needs-assessment;
out-of-hours; after hours; telephone consultations; emergency department, ED
attitude to health; decision-making; help-seeking behaviour; decision to consult

---

[1] Boolean operators such as 'and' (e.g. 'decision-making family' AND 'primary health care' AND 'parental attitudes') and 'or' were used to combine terms (such as 'out-of-hours' or 'after hours') to include the literature regarding out-of-hours care regardless how the paper was indexed. Truncation (the dollar sign '$' or '*') facilitated inclusion of stem words such as 'behavio*r to ensure that all the literature for other countries outside UK was retrieved that might spell a term differently.

Appendix 2 Identification of participants

Appendix 2.1 Identification of participants

PIN[1]	Father	Mother	Serving	Non-serving	Focus group (Phase 1) Focus group number				Interview (Phases 2, 3)	Phase in which interview took place 2 3	
					1	2	3	4		2	3
1	-	x	-	x	x	-	-	-	x	x	
2	-	x	-	x	-	-	x	-	x	x	
3	-	x	-	x	x	-	-	-	-	x	
4	-	x	-	x	x	-	-	-	-	x	
5	-	x	-	x	x	-	-	-	-	x	
6	-	x	-	x	-	-	x	-	x	x	
7	-	x	-	x	x	-	-	-	-	x	
8	-	x	-	x	-	x	-	-	-	x	
9	-	x	-	x	-	x	-		-	x	
10	-	x	-	x	-	x	-	-	-	x	
11	-	x	-	x	-	x	-	-	-	x	
12	-	x	-	x	-	-	x	-	-	x	
13	-	x	-	x	-	-	x	-	-	x	
14	-	x	-	x	-	-	x	-	-	x	
15	-	x	-	x	-	-	x	-	-	x	
16	-	x	-	x	-	-	x	-	-	x	
17	-	x	-	x	-	-	-	x	-	x	
18	-	x	x	-	x	-	-	-	-	x	
19	-	x	x	-	x	-	-	-	x	x	
20	-	x	x	-	-	-	-	x	x	x	
21	x	-	x	-	x	-	-	-	-	x	
22	x	-	x	-	-	x	-	-	-	x	
23	x	-	x	-	-	-	x	-	x	x	
24	x	-	x	-	-	-	-	x	x	x	
25	-	x	-	x					x		x
26	-	x	-	x					x		x
27	-	x	-	x					x		x
28	-	x	-	x					x		x
29	-	x	-	x					x		x
30	-	x	-	x					x		x
31	-	x	x	-					x		x

---

[1] PIN - Personal Identification Number

Appendix 2.2 Phase One: Demographics of each focus group

Focus group	Serving	Rank range of serving	Non-serving mother	Average number of children per participant	Average age of children	Experience of out-of-hours service	Total number that took part each focus group
1	1 Father 1 Mother	Sgt; SSgt	6 (1)[2]	2	4 years 5 months	All	8
2	1 Father	Cpl	4 (3)[2]	2	8 years	All	5
3	1 Father	Sgt	7 (1)[2]	2	2 years 6 months	All but one	8
4	I Mother I Father (1 father)[2]	Sgt; Maj	1 (5)[2]	2	11 years 10 months	All	3

Appendix 2.3 Phase Two: Demographics of participants

Interview	Serving (s) or non serving (ns)	Mother or Father	Focus group	Rank if serving	Spouse serving or non serving	Number Of children	Age
1	NS	Mother	1		S	3	2, 4, 6 years
2	NS	Mother	3		S	2	1, 3 years
3	S	Mother	1	Sgt	S	1	1 year
4	S	Father	3	S Sgt	NS	2	14, 16 years
5	S	Father	4	Sgt	NS	1	4 years
6	NS	Mother	3		S	2	1, 3 years
7	S	Mother	4	Maj	S	1	Nearly 2 years

---

[2] Number committed to taking part but unable to do so on the day the focus group took placce

Appendix 2.4 Phase Three: Child's symptoms that instigated consultation

Inter-view	Serving (S) Non serving (NS)	Length of time part of Army Popul-ation	Number of children in family	Ages/ gender of children[1]	Symptoms of child	Reason for accessing the out-of-hours service	Time lag between seeking treatment for child and interview
1	NS	8 years	2	**21 months Girl** 4 Months Boy	Struggling to breathe, wheezy, high temperature.	Struggling to breathe.	43 days
2	NS	8 years	1	**3 years 11 months Boy**	Rash on chin.	Needed diagnosis to conform If infectious and whether child permitted to attend pre-school next day	9 days
3	NS	13 years	2	**8 years Girl** 6 years Girl	Infected ear lobe due to earrings.	Advised by school, daughter in much pain.	27 days
4	NS	6 years	2	**8 months Girl** 2 years 8 months Girl	High temperature, coughing, not eating or drinking, difficulty breathing, not settling.	Coughing, not eating or drinking, not settling.	36 days
5	NS	4 years	1	**10 months Girl**	High temperature, coughing, epileptic fit (rigor due to high temperature).	Floppy, fit, epileptic fit (rigor due to high temperature)	35 Days
6	NS	7 years	1	**11 months Girl**	Diarrhoea and vomiting, high temperature, irritable.	High temperature, irritable.	20 days
7	S (officer)	10 years	1	**17 months Girl**	Chesty cough, wheezy, sleepy, limp.	Sleepy, limp.	28 days

---

[1]Consultation was with child whose age/ gender is highlighted in bold

Appendix 3 Phase One: Focus group topic guide

	Type of question	Question
1	Introductory Ice breaker 2 minutes	**Please could you tell us your name and the age of your child or children**
	Rationale	- Encourages everyone to talk. - It might identify if there are participants who need more encouragement to speak and those who might dominate the discussion. - Allows identification of different voices for transcription.
2	Key 5 minutes	**How would you explain what Army life is like to someone who knows nothing about the Army?**
	Probes	- What would you tell them about your life? - Think about a time when you were deployed or when your husband/ wife was deployed and if the separation made you want different or additional support than when you are both together. - When you are separated, how do you think this compares to a civilian single parent who has nothing to do with the Army?
3	Key 3 minutes	**Where do you get support from during challenging times such as separation/ deployment?**
	Probes	Whom would you call on when you need emotional or practical support?
4	Key 5 minutes	**Why would you call the out-of-hours service?**
	Probes	- What would make you decide to call out-of-hours service? - What decisions do you think you need to make before you decide to call the out-of-hours service? - What issues would make you decide that your problem couldn't wait until the morning when the medical centre is open again? - What are the circumstances when you would call the out-of-hours service? - If mention geographical access- do you perceive that your requirements are any different from civilian families living in the area?
5	Key 5 minutes	**How would you want the out-of-hours service to help you once you have contacted it?**
	Probes	- What would you expect the out-of-hours service to do for you? - Think about a situation when you felt or would feel that you needed to contact a doctor when you felt it couldn't wait until the medical centre was open the next morning?
6	Key 7 minutes	**What influences your decision as to what is most important thing for the out-of-hours service to provide for you?**
	Probes	Sometimes one has to make a trade off and make a decision in one's mind of what is most important

	Type of question	Question
7	Key 5 minutes	**Do you feel you need any different or additional care or support from the out-of-hours service during times of separation?**
	Probes	• Think about a time when you were deployed or when your husband/ wife was deployed and whether the separation made you want different or additional support than when you are both together • Do you think the Army way of life means you have particular or additional requirements that are different from civilian families who have nothing to do with the Army? • Does it make any difference whether it occurs during deployment or other separation such as courses/ exercise • What if any, additional or different care/ support would you want from the out-of-hours service during these particularly challenging times? • Do these requirements change at different times- such as when you are separated?
8	Ending 5 minutes	**What do you think is the most important thing we have discussed today?**
	Probe	• What matters to you most?
9	Ending 1 minute	**Are there any other points that anybody wanted to raise and haven't had a chance to yet?**
10	Summary 1 minute	**Is this an accurate summary of what was said?**
		• Moderator summarised what has been said and asked for confirmation whether this was an accurate summary

The following general probes were used to encourage participants to explore the issues that they were raising if appropriate to do so:

- Why do you think that?
- What do you think about that?
- How does that affect you/ your family?
- Can you tell me / expand a bit more about that?
- Why is that?
- Can you give me an example?
- Can you describe for me what you mean?
- How would you explain that to someone who has nothing to do with/ any understanding of what Army life/ the Army is like?
- Do you have anything else to add?

Appendix 4 Phase Two: Interview topic guide

	Type of question	Question
1	**Introductory Ice breaker**	**Please could you tell me your name and confirm again the age of your child or children** **How long you have been involved with the Army or part of an Army family?**
2	**Key**	**What is a typical day within an Army community like for you?**
	Probes	• What would you tell someone who knows nothing about the Army about your life? • How do you think your day would be different if you or your family had nothing to do with the Army? • How is Army life compared to what you expected it to be before you became part of it? • Has Army life changed for you over the past few years –if so how?
3	**Key**	• How do you think your day would be different if you or your family had nothing to do with the Army?
	Probes	• What would you tell someone who knows nothing about the Army about your life? • How is Army life compared to what you expected it to be before you became part of it? • Is Army life any different from when you first experienced Army life?
4	**Key**	• How does your life change when your husband is away on deployment/ training exercises/ courses?
	Probes	• How does this differ depending on the length and why he is away i.e. is it different whether he is away because he is deployed or away on exercise or a course? • How does the length of time that you are separated affect your need for support? • When you are separated, how do you think your life compares to a civilian single parent who has nothing to do with the Army?
5	**Key**	• How you feel that Army life impacts on what you would like the out-of-hours service to provide for you and your family?
	Probes	• Think about a situation when you felt or would feel you needed to contact a doctor when you felt it couldn't wait until the medical centre was open the next morning? • What was your situation at the time when you needed support?

The following general probes were used to encourage participants to explore the issues that they were raising if appropriate to do so:

- Why do you think that?

- What do you think about that?

- How does that affect you/ your family?

- Can you tell me / expand a bit more about that?

- Why is that?

- Can you give me an example?

- Can you describe for me what you mean?

- How would you explain that to someone who has nothing to do with/ any understanding of what Army life/ the Army is like?

- Do you have anything else to add?

Appendix 5 Phase Three: Interview topic guide

	Type of question	Question
1	Ice breaker	**Please could you tell me your name and confirm the age of your child or children** **How long you have been involved with the Army or been part of an Army family?** (plus any other demographics that may be relevant) **Where is your husband at the moment?**
2	Key	**Please can you describe the events that led you to call a nurse or doctor when [name of child] was unwell?**
	Probes	• What led you to call them at that particular time? • What did you think the problem was? • What did you know about the problem? • Who, if anyone did you talk to about it? • Had you thought of seeing your GP about it beforehand? • Why did you call when you did? • Can you give me a timeline of events? • Did you think of contacting or going to any other health service (e.g. out-of-hours clinic/ A and E/ Pharmacy) before contacting out-of-hours clinic/ A and E[1]? • What made you decide to contact A and E rather than out-of-hours clinic? (if applicable)
3	Key	**What happened when you called the clinic/ the Accident and Emergency Department[1]?**
	Probes	• Did someone arrange to call you back? • Do you know when they would call you back? • Did they give you an appointment- clinic/ home visit? • Did you know what to expect • Did anything surprise you?
4	Key	**What was it like attending the out-of-hours clinic/ Accident and Emergency Department??**
	Probes	• Did you know what to expect? • What did you expect? • Anything that you did not expect/ or surprised you? • What did you want from the consultation?
5	Key	**How would you rate the experience?**
	Probes	• What aspects were you pleased about? • What was good? • What could have made it better?

The following general probes were used to encourage participants to explore the issues that they were raising if required or appropriate to do so:

---

[1] Used term 'the Accident and Emergency Department' as this term used by participants in previous fieldwork, none has used the term 'ED'.

- Why do you think that?
- What do you think about that?
- How does that affect you/ your family?
- Can you tell me / expand a bit more about that?
- Why is that?
- Can you give me an example?
- Can you describe for me what you mean?
- How would you explain that to someone who has nothing to do with/ any understanding of what Army life/ the Army is like?
- Do you have anything else to add?

Appendix 6 The data analysis process

The data analysis process
Listen to recording of data (get to know data)
↓
Note down any important features or preliminary themes
↓
Transcribe verbatim
↓
Start thinking as typing what information is being gained from the data to contribute to answering the research questions
↓
Start preliminary coding and categorising by going through the data word for word, line by line
↓
Highlight text using different colours
↓
Identify code in 'free nodes' on NVivo 7™
↓
Print off 'free nodes'
↓
Group nodes into abstract concepts (start theme development)
↓
Identify name for groups
↓
Develop 'tree nodes' on NVivo 7™ to link codes
↓
Link codes into themes
↓
Repeat process for each transcript
↓
Compare codes and developing themes between each data set
↓
Re-examine each transcript to check if any additional codes missed (avoid premature closure)
↓
Re-examine literature to identify how themes are similar or difference to the data
↓
And if there is a reason for this e.g. Serving/ non-serving or mother/ father
↓
Supervisors code some data independently
↓
Re- examine data to check no further themes missed
↓
Repeat for each data set
↓
Review transcripts as a whole
↓
Discuss theme development with supervisors
↓
Identify the impact of analysis on further fieldwork
↓
Identify how my position may have influenced the data and my analysis
↓
Interpretation
↓
Writing up (be open to further thematic development during write up)

(Informed by Pope and Mays 2006; Silverman 2006; Holloway and Wheeler 2010)

Appendix 7 An example of data analysis

The data was coded word-by-word and line-by-line as Appendix 7.1 demonstrates.

Appendix 7.1 Example of how codes were developed

Except from data to be coded	Coding
Iv(2) NM:29 *So she* [baby daughter] *had rigors and I thought it was rigors that she had 'cause her temperature had gone so high, and I didn't know if that's something that babies get or they don't get.*	rigors I thought it was rigors temperature had gone so high I didn't know babies get or they don't get
So I obviously - my immediate thing was to pick her up and comfort her 'causes it's not particularly nice to have that. And as I picked her up, her – you know, her limbs were like sort of – em – her limbs were shaking and she – her eyes rolled to the back of her head. And then they came forward again, and then they rolled back again, and came forward again. And this happened three times. And then she just went limp in my arms- Not limp in that she wasn't breathing, limp in -. And I knew what had happened, I knew that she'd had - But you know that way where you think - 'Did I imagine that? Or did I think that that had happened because I know about it?'.	my immediate thing to pick her up and comfort her her limbs were shaking her eyes rolled to the back of her head. happened three times went limp in my arms Not limp in that she wasn't breathing, Did I imagine that? did I think that that had happened because I know about it?'
And so I kind of thought that that's what she'd had. She'd had a febrile convulsion. And just prior to her having that, her temperature was sort of like 40.6°C I think it was. So just prior – again prior to having that I'd given her Calpol™ 'cause her temperature had gone up so high, and then that happened.	I kind of thought febrile convulsion temperature 40.6°C I'd given her Calpol™ her temperature had gone up so high,
So I rang – em- . I didn't know what to do – you know that way where you don't know what to do! I was like – you know you think 'does it warrant you going to the hospital? Or does it not? Or – ' you know and she was -. Although she'd gone, she'd gone limp and all that sort of post fit phase where you go well not so much rigidity but you know, when you go – em – really lethargic, really can't be bothered, em, she didn't just want to cuddle in and she was non-responsive, you know, she didn't want to communicate with me or anything like that, so I kind of knew that's what had happened to her.	I didn't know what to do does it warrant you going to the hospital? she didn't just want to cuddle in she was non-responsive
I knew that she was fine, so I rang my mother of all people, I don't know why I did that. I rang my Mum – and em – again at that point I was like "what do you do?" – I was – and the snow was really bad outside [husband's name] wasn't here, my husband wasn't here................	I knew that she was fine I rang my Mum the snow was really bad I was like "what do you do?" my husband wasn't here

The codes were then grouped together to form categories as Appendix 7.2 demonstrates.

Appendix 7.2 Example of how codes developed into categories

Codes	Category
rigors I thought it was rigors temperature had gone so high her limbs were shaking her eyes rolled to the back of her head. happened three times went limp in my arms Not limp in that she wasn't breathing, I knew that she was fine	Trying to make a diagnosis
does it warrant you going to the hospital?	What's best?
Rigors I thought it was rigors temperature had gone so high febrile convulsion temperature 40.6°C her temperature had gone up so high her limbs were shaking her eyes rolled to the back of her head. happened three times went limp in my arms Not limp in that she wasn't breathing, Babies happened three times went limp in my arms Not limp in that she wasn't breathing	Trying to understand
I'd given her Calpol™	Trying to manage condition herself
temperature 40.6°C	Monitoring child's condition
temperature 40.6°C Rigors I'd given her Calpol™ her limbs were shaking her eyes rolled to the back of her head. Not limp in that she wasn't breathing,	Using own medical knowledge
rigors I thought it was rigors temperature had gone so high Babies her limbs were shaking her eyes rolled to the back of her head. temperature 40.6°C I'd given her Calpol™ get or they don't get	Knowledge of illness

Codes	Category
she didn't want to cuddle in her limbs were shaking her eyes rolled to the back of her head. temperature 40.6°C she was non-responsive	Deterioration child's behaviour
my immediate thing I rang my mother of all people, I don't know why I did that my husband wasn't here	Sense of urgency
I didn't know did I think that that had happened because I know about it?' get or they don't get Did I imagine that? I rang my mother of all people, I don't know why I did that	Questioning own judgment
I didn't know did I think that that had happened because I know about it?' Did I imagine that? I rang my mother of all people I don't know why I did that	Lack of confidence in own decision-making
I'd given her Calpol™ her temperature had gone up so high, to pick her up and comfort her Babies I picked her up my husband wasn't here	Protective of child
not particularly nice to have that.	Empathy
my husband wasn't here- I rang my Mum I didn't know what to do I was like "what do you do?"	Anxiety and fear
I didn't know did I think that that had happened because I know about it?' Did I imagine that? I rang my mother of all people, I don't know why I did that	Not trusting own instinct
did I think that that had happened because I know about it?' Did I imagine that?	Questioning whether an event took place
I rang my Mum	Need to transfer responsibility

Codes	Category
I was like "what do you do?" does it warrant you going to the hospital?	Lack confidence in own ability to cope
my husband wasn't here	Have to get on with it
my husband wasn't here I was like "what do you do?"	Have to cope alone
I rang my Mum I didn't know what to do	Panic
I rang my Mum does it warrant you going to the hospital? my husband wasn't here	Share the responsibility
I rang my Mum going to the hospital	Need to ease the burden
I rang my Mum does it warrant you going to the hospital?	Call someone you trust
does it warrant you going to the hospital?	Question if appropriate person to call
does it warrant you going to the hospital?	Trying to make a decision
the snow was really bad my husband wasn't here I knew that she was fine does it warrant you going to the hospital? febrile convulsion temperature 40.6ºC I'd given her Calpol™ Did I imagine that? her temperature had gone up so high, I didn't know what to do does it warrant you going to the hospital? I knew that she was fine I rang my Mum I was like "what do you do?" my husband wasn't here-	Weigh up the situation

Categories were linked together to form themes and is demonstrated in Appendix 7.3. These themes are reflected in the findings in Chapter 4.

Appendix 7.3 Example of how categories developed into themes

Category	Themes
Trying to understand Trying to manage condition herself Monitoring child's condition Using own medical knowledge	Making sense of the illness or injury
Knowledge of illness Deterioration child's behaviour Sense of urgency Questioning own judgment Not trusting own instinct	Fear of rapid deterioration and serious illness
Call someone you trust What's best Question if appropriate person to call Trying to make a decision Empathy Weigh up the situation	Doing the right thing
Fear and anxiety Lack of confidence in own decision-making Questioning whether an event took place Need to transfer responsibility Lack confidence in own ability to cope Have to get on with it Have to cope alone Panic Share the responsibility Need to ease the burden	Impact of husband's presence or absence

Appendix 8 Invitation letters

Appendix 8.1 Phase One– Initial invitation letter

School of Nursing and Midwifery
University of Southampton
Highfield
Southampton
SO17 1BG
Tel: ▇▇▇▇▇▇▇▇
Email: ▇▇▇▇▇▇▇

Invitation to take part in a study about out-of-hours care for Army families

I am an Army nurse undertaking a research study at the University of Southampton. My research is investigating out-of- hours[10] care for Army families with young children in ▇▇▇▇▇. The out-of-hours service is very important because it enables you and your family to receive help and advice when your medical centre is closed. While quite a lot is known about what are the most common symptoms that cause parents to call the out of hours service; not much is known about what concerns soldiers and their families when the medical centre is closed.

I would like to invite you to take part in an informal confidential discussion with up to 7 others in April or May to discuss what help and advice you think you might need from the out-of-hours service when your medical centre is closed. The discussion will take no more than one hour of your time and will take place in ▇▇▇▇▇ which is next to the medical centre. Refreshments will be available before and after the discussion has taken place. Finding out your views is very important; regardless of whether or not you have used the out-of-hours service in the past; so that recommendations can be made to develop out-of-hours services in the future.

If you are interested in taking part in this study; please contact me via E-mail ▇▇▇▇▇▇. telephone ▇▇▇▇▇.or by returning the enclosed reply section overleaf to me as soon as you can. A FREEPOST envelope is enclosed which can be posted in the military mail system or Royal Mail; whichever is easier for you. As soon as I have heard from you, I will send some further information about the study to you and then contact you after a week to check that you have received this and ask you if you have any questions. If you prefer not to take part for any reason it would be very helpful to know why, so you are welcome to return the Reply Slip and add your reasons on the back of the form. If I do not hear from you I shall not contact you again.
This study is being funded by the Army Medical Services and has been approved by the Ministry of Defence research ethics committee.

Do not hesitate to contact me if you wish to know any more information about the study or how it will involve you.

---

[10] The National Health Service out-of-hours (OOHs) service 18.30 Monday to Thursday to 08.00 on the following day, 18.30 on Friday to 08.00 on the following Monday and Public Holidays. Between 16.30 -18.30 Monday to Friday an out-of-hours' clinic is held at the garrison's medical centre.

Thank you for reading this. I look forward to hearing from you.

Yours sincerely,

Lizzy Bernthal

Enclosure:

FREEPOST envelope

✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂✂

Out-of-hours care for Army families with young children

REPLY FORM

If you think you would be interested in taking part in this study, please fill out your name, address and telephone number below, the best time to call and your E-mail address if you have one. If you prefer not to take part for any reason it would be very helpful to know, so please return this Reply Slip and add your reasons on the back of this form.

Name:

Address:

Telephone number(s):

E-Mail address:

Best time to call:

Please place this page in the FREEPOST envelope provided then seal and post the envelope in the military mail or Royal Mail.

Thank you.

Appendix 8.2 Phase One- Follow up letter

MoDREC protocol number: 0744/129

University of Southampton | School of Nursing and Midwifery

School of Nursing and Midwifery
University of Southampton
Highfield
Southampton
SO17 1BG
Tel: ███████████
Email: ███████████

Date:

Dear

Out-of-hours care for Army families with young children

Thank you for expressing an interest in taking part in this study. I have enclosed some more information about the study so that you can have a greater understanding of what the study is about and how it will involve you. The information enclosed is for you to keep.

I shall contact you in about a week's time. This is so I can answer any further questions that you may have about the study or participating in it and if you are still interested in taking part, to arrange a convenient time with you for your discussion to take place.

Meanwhile do not hesitate to contact me via the details above if you want to know any more information.

Thank you for reading this and for expressing an interest in taking part.

I look forward to hearing from you.

Lizzy Bernthal

Enclosure:

Participant information leaflet

Appendix 8.3 Phase One- Final letter

MoDREC protocol number:
University of Southampton REC number:
Patient Identification Number for this study:

                                                    School of Nursing   and
                                                    Midwifery
                                                    University of Southampton
                                                    Highfield
                                                    Southampton
                                                    SO17 1BG
                                                    Tel: ▮▮▮▮▮
                                                    Email: ▮▮▮▮▮

Dear

Out-of-hours care for Army families with young children

Thank you for agreeing to take part in a discussion group for this study. The aim of the discussion is to find out your general views of what you require, expect and need if you child is unwell when the medical centre is closed (see the participant group discussion guide enclosed). There will be no need to ask you to divulge any information that is medical in confidence. Please allow up to an hour for the discussion group to take place. The actual discussion should take 45 minutes, however a few minutes extra will be required to sign and witness the consent forms and to allow time for a summary of the discussion at the end; another sample consent form is enclosed for your information. There will be tea and coffee available before the discussion takes place and a light snack available afterwards.

It will be quite informal; please wear casual clothing rather than uniform; the use of first name terms will be encouraged if you are happy with that. You may leave the group at any time if you wish. It is not possible to predict whether you will know the others in your discussion group. All of you have been invited to take part because you might be using the out-of-hours service in the future.

Please ensure that the contents of the discussion are not divulged to anyone outside the group so that the rest of the group's and your own confidentiality can be maintained.

The details of the timings and location of the discussion group can be seen below:

        Location:
        Date:
        Time:

Details of how to get to ▮▮▮▮▮ are enclosed. Should you have any problem on the day do not hesitate to contact me on my mobile ▮▮▮▮▮.

I shall contact you the day before to confirm that you can attend and answer any further questions.

Thank you very much for agreeing to participate. I look forward to meeting you.

Lizzy Bernthal

Researcher

Enclosures:

1.   Directions to ███████
2.   Sample consent form.

Appendix 8.4 Phase Two - Invitation letter

UNIVERSITY OF
Southampton
School of Health Sciences

<Recipient name and address>

<Date>

Dear

Out-of-hours care for Army families

Thank you for your valuable contribution in a discussion to give your views about what it is like to be part of an Army family and what you expect the out-of-hours service to provide for you. The results of the feedback from the statements are enclosed for your information.

It is clear that Army life creates many challenges, particularly during separation, and that it is very important for the civilian doctors and nurses that provide out-of-hours care for Army families to understand what these challenges are. In light of this finding, I am interested in exploring what Army life is like in greater depth. This would help me to develop information that could be used to help civilian nurses and doctors gain a greater understanding of Army life and what Army families expect out-of-hours services to provide them.

I would like to invite you to meet with me so that I can ask you more about what Army life is like for you, such as what your typical day is like. This should take no more than an hour and can take place at a time, date and place of your convenience including evenings and weekends. It can take place either in your home, if that is easier for you, or at another convenient location. You are under no obligation to take part and can withdraw at any time. Should you agree to talk to me, only I shall be present; your family are welcome to listen if you wish them too and I appreciate that your children might need your attention while I am with you. All the information that you provide will be anonymous and kept secure.

If you are interested in talking to me, please E-mail me ▮▮▮▮▮▮; or telephone/ text me ▮▮▮▮▮▮ or return the enclosed reply section overleaf to me as soon as is convenient to you so that I know that I have your permission to contact you again. The FREEPOST envelope can be posted in the military mail system or Royal Mail, whichever is easier for you. As soon as I have heard from you, I will contact you to answer any questions and to ask whether you still wish to take part to and send you some further information. Do not hesitate to contact me if you wish to know any more information or how it will involve you.
I look forward to hearing from you again soon. If I do not hear from you I shall not contact you again.

Yours sincerely

Lizzy Bernthal
Researcher

Enclosures:

1.   Results of the responses to the statements
2.   FREEPOST envelope

✄✄

Out-of-hours care for Army families

REPLY FORM

If you think you would be interested in taking part in a one to one conversation, please update any of the details below including your E-mail address if you have one and indicate the best time for me to call you.

Name:

Address:

Telephone number(s):   Landline:

                            Mobile:
E-Mail address:

Best time to call:

Please place this page in the FREEPOST envelope provided then seal and post the envelope in the military mail or Royal Mail.

Thank you very much.

UNIVERSITY OF
Southampton

School of Health Sciences

**Out-of-hours care for Army families
Results of the responses to the statements summarising the discussion groups**

<u>Combined feedback from participants to the summary statements</u>
Each person completing the form below circled a box to show whether they agreed or disagreed with each statement. The new table below shows the results of adding the responses together from all those that took part. Instead of a circle in each box there is a number showing the percentage of people who ticked this answer. The box that was ticked most often is shaded in so that it can be seen easily.

	Statement	Strongly agree (SA) (%)	Agree (A)(%)	SA and A(%)	Neutral (%)	Disagree (%)	Strongly disagree (%)	Total (%)
1	My life is very different from those people I know who have nothing to do with the Army	37.5.	56.3	**93.8**	6.2	0	0	100
2	Protection of my children is one of the most important things in my life	93.8	6.2	**100**	0	0	0	100
3	I would like to have greater control over the short, medium and long term future for my family	62.5	25.0	**87.5**	12.5	0	0	100
4	The expectations of the Army as an organisation are sometimes at odds with my needs and those of my family	43.8	56.2	**100**	0	0	0	100
5	I or my partner feel in a no-man's land if not serving as neither serving nor a true civilian	25.0	43.8	**68.8**	6.2	25.0	0	100
6	Aspects of Army life, such as prolonged separation and the disruption it causes, increases my and/or my family's need for support	43.8	56.2	**100**	0	0	0	100
7	Army life impacts on what I want the out-of-hours service to provide for me and my family	56.3	25.0	**81.3**	18.7	0	0	100
8	The out-of-hours service must understand what my Army life is like	40.0	40.0	**80.0**	20.0	0	0	100
9	Compared with the civilian families in ▇▇▇▇, being part of an Army family creates a greater need for an out-of-hours service that is within walking distance	43.8	31.2	**81.3**	25.0	0	0	100
10	I call the out-of-hours service for reassurance for me as much as for the treatment of my child's illness or injury	43.8	37.5	**81.3**	18.7	0	0	100
	A greater understanding is needed when dealing with families when partner is away[11]	x						
	Special support services are required during times of separation	x						
	The doctors at the service of Army families must be at ease and knowledgeable of children's health and diseases	x						
	The Army sends conflicting messages regarding family: that we are important when really we are not and only secondary to their needs.	x						

---

[11] Additional statements received in one completed questionnaire- x the shaded area marks the same box as the response

Appendix 8.5 Phase Three– Invitation letter

UNIVERSITY OF
Southampton
School of Health Sciences

Participant's name and address

Date

Dear

Invitation to take part in a study about out-of-hours care for Army families
I am an Army nurse undertaking a research study at the University of Southampton. My research is investigating out-of-hours[1] care for Army families with young children in ▉▉▉▉▉. Out-of-hours care is very important because it enables families to receive help and advice when their medical centre is closed. While quite a lot is known about what are the most common symptoms that cause parents to call out of hours services, not much is known about what concerns Army families when the medical centre is closed and why they call when they do.

You have received this letter as I have asked the nurses to invite you to talk to me about the factors that helped you to decide to contact a nurse or a doctor when your child was unwell recently. Talking to me will be very informal, it should take no more than an hour and can take place at a time, date and place of your convenience, including evenings and weekends. It can take place either in your home, if that is easier for you, or at another convenient location. You are under no obligation to take part and can withdraw at any time. Only I shall be present, your family are welcome to listen if you wish them too and I appreciate that your children might need your attention while I am with you. All the information that you provide will be anonymous and kept secure.

Hearing your views will help me to make recommendations to develop out-of-hours services in the future for Army families and to develop information that could be used to help civilian nurses and doctors gain a greater understanding of Army life and what Army families expect out-of-hours services to provide for them.

If you are interested in taking part in this study, please contact me via E-mail ▉▉▉▉▉ telephone/ text ▉▉▉▉▉ or by returning the enclosed reply slip below.

Some more information about the study is enclosed as well as a FREEPOST envelope which can be posted in the military mail system or Royal Mail, whichever is easier for you. As soon as I have heard from you that you are still interested talking to me, I shall contact you at the most convenient time and way you have indicated

---

[1] The National Health Service out of hours period is defined as the period beginning at 18.30 on any day from Monday to Thursday and ending at 08.00 on the following day, the period between 18.30 on Friday and 08.00 on the following Monday and Public Holidays. As Army medical centres close at 16.30, there is a regional out-of-hours clinic 16.30 -18.30 Monday to Friday held at garrison's medical centre.

to arrange a convenient place and time for our conversation to take place, as well as answer any questions that you may have. If I do not hear from you I shall not contact you again.

Do not hesitate to contact me if you wish to know any more information about the study or how it will involve you.

I look forward to hearing from you soon.

Thank you for reading this.

Yours sincerely,

Lizzy Bernthal

Researcher

Enclosures:

1.   Participant information leaflet.
2.   Sample consent form.
3.   Topics for discussions leaflet.

✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄✄

Out-of-hours care for Army families

REPLY FORM

If you think you would be interested in taking part in a one to one conversation, please update any of the details below including your E-mail address if you have one and indicate the best time for me to call you.

Name:

Address:

Telephone number(s):   Landline:

                              Mobile:
E-Mail address:

Best time to call:

Please place this page in the FREEPOST envelope provided then seal and post the envelope in the military mail or Royal Mail.

Thank you very much.

Appendix 9 Participant information leaflets

Appendix 9.1 Phase One

UNIVERSITY OF
Southampton
School of Health Sciences

PARTICIPANT INFORMATION LEAFLET
Out-of-hours care for Army families
Invitation to take part in a research study

Thank you so much for your willingness to participate in this study so. You are being invited to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Participation is entirely voluntary.

Thank you for reading this.

What is the purpose of this study?
The aim of this study is to investigate out-of- hours[2] care for Army families with young children in ▮▮▮▮▮▮▮. Having a better understanding of this will enable recommendations to be made to help develop out-of-hours services in the future.

Why have I been chosen?
You have been invited, as I would like to hear the views of serving Army parents who have young children within ▮▮▮▮▮▮

Who is undertaking the study?
I am an Army nurse who is undertaking some research at the University of Southampton.

Do I have to take part?
No. Participation is entirely voluntary; if you decide to take part you can change your mind and withdraw at any time. Any decision you make will not affect the

---

[2] The National Health Service out-of-hours (OOHs) service 18.30 Monday to Thursday to 08.00 on the following day, 18.30 on Friday to 08.00 on the following Monday and Public Holidays. Between 16.30 -18.30 Monday to Friday an out-of-hours' clinic is held at the garrison's medical centre.

standard of care you receive, if you are serving, any information that you give will be confidential and will not be discussed with your Chain of Command.

What will happen if I still wish to take part?
I will contact you in about a week's time to answer any further questions that you may have about this study or participating in it and if you are still interested in taking part, to arrange a convenient time and location with you for your discussion to take place. I shall then confirm the date, time and location of the discussion in writing and send you directions where the discussion will take place.

Taking part in this informal discussion will take up to one hour and will involve up to 8 of you discussing what help and advice you think you might need from the out-of- hours service when your medical centre is closed. A leaflet about the topics for discussion is enclosed. Refreshments will be available before and after the discussion has taken place.

After the discussion has taken place, I shall send you a summary of the issues that your group has identified and invite you to comment on them. After this your contribution to this study will be complete, unless you wish to take part in further stages of the study.

Do I need to sign a consent form?
Yes, so that I have written confirmation that you agree to take part in a discussion, for it to be tape recorded and for notes to be taken so that I can clarify the contents of your discussion in detail after it is over. Consent forms will be waiting for you on the day; you do not need to bring any paperwork with you. A sample consent form is enclosed for your information.

What are the possible benefits of taking part?
Knowing your views will help make recommendations to develop out-of-hours services in the future for you and your family.

What will happen if I decide not to take part?
You are not under any obligation to take part.

What are the possible disadvantages of taking part?
The discussion will take approximately one hour of your time.
Who is funding the research?
The study is being funded by the Defence Medical Services.

Who is providing sponsorship and professional indemnity for the study?

Sponsorship and professional indemnity is being provided by the University of Southampton, Legal Services. Building 37, Highfield, Southampton, SO17 1BJ

Who has reviewed the study?

This study has been approved by the Ministry of Defence Research Ethics Committee.

Will my involvement in this study be kept strictly confidential?

Yes. The procedures for handling, processing, storage and destruction of the data comply with the Data Protection Act 1998. This means that information about your contact details will be kept in a secure location separate from the information collected during the discussion group.

If you are taking part you must ensure that the content of your discussion is not disclosed to anyone outside the group so that the rest of the group and your own confidentiality is maintained. The only exception would be in the very unlikely event that there is evidence that the safety of vulnerable adults, children or yourself may be at risk. In this case I would have to disclose relevant information to an appropriate third party.

Only my two supervisors and I will have access to the audiotapes of your discussion. There will be no individually identifiable material in my report. Both the recording and the transcription will be stored anonymously using a code number for reference and not your name or anything that could identify you.

After the study has finished any data relating to the study will be stored securely for ten years by University of Southampton. After this period the Ministry of Defence will review whether it wishes to store the data securely for a further five years or destroy it in accordance with Ministry of Defence policy. All information will be entirely confidential.

What will happen to the results of the research?

It will be used to develop another part of the study. Your contribution to this part of the study will always remain confidential. You will not be involved in a further part of the study unless you wish to be.

What if there is a problem or I have a complaint?

If you have a concern or a complaint about the conduct of this study you should contact the Research Office at the University of Southampton on ▮▮▮▮▮▮▮▮ or by emailing ▮▮▮▮▮▮▮▮▮▮▮

In the highly unlikely event of you suffering any adverse effects as a consequence of your participation in this study, you will be eligible to apply for compensation under the Ministry of Defence's 'No Fault Compensation Scheme'.

If you have any questions do not hesitate to contact me.

Thank you very much for considering taking part in this study.

Contact details of researcher:

Lizzy Bernthal

School of Nursing and Midwifery

University of Southampton

Highfield

Southampton

SO17 1BG

Mobile telephone/text: ▮▮▮▮▮▮▮▮

E-mail: ▮▮▮▮▮▮▮

Appendix 9.2 Phase Two

UNIVERSITY OF
Southampton
School of Health Sciences

PARTICIPANT INFORMATION LEAFLET
Out-of-hours care for Army families
Invitation to take part in a research study

Thank you so much for your willingness to participate in this study so. You are being invited to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Participation is entirely voluntary.

Thank you for reading this.

What is the purpose of this study?
The aim of this study is to investigate out-of- hours[3] care for Army families with young children. Having a better understanding of this will enable recommendations to be made to help develop out-of-hours services in the future for Army families.

Why have I been chosen?
You have been invited as I would like to explore some of the issues that were identified in the discussion groups that took place in April and May in greater detail.

Who is undertaking the study?
I am an Army nurse who is undertaking some research at the University of Southampton.

Do I have to take part?
No. Participation is entirely voluntary; if you decide to take part you can change your mind and withdraw at any time. Any decision you make will not affect the

---

[4] The National Health Service out-of-hours (OOHs) service 18.30 Monday to Thursday to 08.00 on the following day, 18.30 on Friday to 08.00 on the following Monday and Public Holidays. Between 16.30 -18.30 Monday to Friday an OOHs clinic is held at the garrison's medical centre.

standard of care you receive, if you are serving, any information that you give will be confidential.

What will happen if I still wish to take part?

I will contact you in about a week's time to answer any further questions that you may have about this study or participating in it. If you are still interesting in taking part when I call you, I shall arrange a convenient time and location with you for our conversation to take place. I shall then confirm the date, time and location where it is to be held in writing and send you directions if you would prefer to meet somewhere other than in your home.

Talking to me will take up to one hour and will involve giving me your views as to what Army life is like for you and your family and how it impacts on what you would like the out-of- hours service to provide for you when your medical centre is closed. A leaflet about the topics I would like to discuss with you is enclosed.

Do I need to sign a consent form?

Yes, so that I have written confirmation that you have agreed to talk to me, for our conversation to be tape recorded and for notes to be taken so that I can clarify the contents of our conversation in detail after it is over. I shall send you a consent form prior to our meeting as you need to have your signature witnessed. A sample consent form is enclosed for your information.

What are the possible benefits of taking part?

Knowing your views will help make recommendations to develop out-of-hours services in the future for you and your family.

What will happen if I decide not to take part?

You are not under any obligation to take part.

What are the possible disadvantages of taking part?

Our conversation will take approximately one hour of your time.

Who is funding the research?

The study is being funded by the Defence Medical Services.

Who is providing sponsorship and professional indemnity for the study?

Sponsorship and professional indemnity is being provided by the University of Southampton, Legal Services. Building 37, Highfield, Southampton, SO17 1BJ.

Who has reviewed the study?
This study has been approved by the Ministry of Defence Research Ethics Committee.

Will my involvement in this study be kept strictly confidential?
Yes. The procedures for handling, processing, storage and destruction of the data comply with the Data Protection Act 1998. This means that information about your contact details will be kept in a secure location separate from the information collected during the discussion group.

Whatever you say will be in total confidence. The only exception would be in the very unlikely event that there is evidence that the safety of vulnerable adults, children or yourself may be at risk. In this case I would have to disclose relevant information to an appropriate third party.

Only my two supervisors and I will have access to the audiotapes of your discussion. There will be no individually identifiable material in my report. Both the recording and the transcription will be stored anonymously using a code number for reference and not your name or anything that could identify you.

After the study has finished any data relating to the study will be stored securely for ten years by University of Southampton. After this period the Ministry of Defence will review whether it wishes to store the data securely for a further five years or destroy it in accordance with Ministry of Defence policy. All information will be entirely confidential.

What will happen to the results of the research?
The results should help create a detailed description of what Army life is really like for Army families. This could be used to help civilian nurses and doctors to gain a greater understanding of the challenges faced by Army families what Army families expect the out-of-hours service to provide for them.

What if there is a problem or I have a complaint?
If you have a concern or a complaint about the conduct of this study you should contact the Research Office at the University of Southampton on ▮▮▮▮▮▮▮▮ or by E-mailing ▮▮▮▮▮▮▮▮▮▮▮▮

In the highly unlikely event of you suffering any adverse effects as a consequence of your participation in this study, you will be eligible to apply for compensation under the Ministry of Defence's 'No Fault Compensation Scheme'.

If you have any questions do not hesitate to contact me.

Thank you very much for considering taking part in this study.

Contact details of researcher:

Lizzy Bernthal
School of Nursing and Midwifery
University of Southampton
Highfield
Southampton
SO17 1BG
Mobile telephone/text: ███████████
E-mail: ███████████

Appendix 9.3 Phase Three

UNIVERSITY OF
Southampton
School of Health Sciences

PARTICIPANT INFORMATION LEAFLET

Out-of-hours care for Army families

Invitation to take part in a research study

Thank you so much for your willingness to participate in this study so. You are being invited to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Participation is entirely voluntary.

Thank you for reading this.

What is the purpose of this study?
The aim of this study is to investigate what makes parents within Army families decide to contact a nurse or a doctor if their child is unwell and their medical centre is closed[4]. Having an understanding of this will enable recommendations to be made to help develop out-of-hours services for Army families in the future.

Why have I been chosen?
You have been invited because you required an emergency appointment with the doctor or nurse recently when your child was unwell.

Who is undertaking the study?
I am an Army nurse who is undertaking some research at the University of Southampton.

What will happen if I still wish to take part?
Once I have heard from you that you are interested in taking part, I shall contact you to answer any questions and find out if you are interested in talking to me. If

---

[4] The National Health Service out-of-hours (OOHs) service 18.30 Monday to Thursday to 08.00 on the following day, 18.30 on Friday to 08.00 on the following Monday and Public Holidays.

you are able to do so, I shall arrange a convenient time and location with you for our conversation to take place. I shall then confirm the date, time and location where it is to be held in writing and send you directions if you would prefer to meet somewhere other than in your home. Talking to me will take up to one hour and will involve talking to me about your experience when your child was unwell.

What are the possible benefits of taking part?
Knowing your views will help make recommendations to develop out-of-hours services in the future for you and your family.

Do I need to sign a consent form?
Yes, so that I have written confirmation that you have agreed to talk to me, if you are happy for our conversation to be tape recorded for me to take some notes so that I can clarify the contents of our conversation in detail after it is over. I shall send you a consent form prior to our meeting, as you need to have your signature witnessed.

Do I have to take part?
No, you are under no obligation to take part, participation is entirely voluntary. If you decide to participate, you can change your mind and withdraw at any time and can have the tape of your conversation destroyed. Any decision you make will not affect the standard of care you receive.

What are the possible disadvantages of taking part?
Our conversation will take approximately one hour of your time.

Who is funding the research?
The study is being funded by the Defence Medical Services.

Who is providing sponsorship and professional indemnity for the study?
Sponsorship and professional indemnity is being provided by the University of Southampton, Legal Services. Building 37, Highfield, Southampton, SO17 1BJ.

Who has reviewed the study?
This study has been approved by the Ministry of Defence Research Ethics Committee.

Will my involvement in this study be kept strictly confidential?
Yes. The procedures for handling, processing, storage and destruction of the data comply with the Data Protection Act 1998. This means that information about your

contact details will be kept in a secure location separate from the information collected during the discussion group.

Whatever you say will be in total confidence. The only exception would be in the very unlikely event that there is evidence that the safety of vulnerable adults, children or yourself may be at risk. In this case I would have to disclose relevant information to an appropriate third party.

Only my two supervisors and I will have access to the audiotapes of our discussion. There will be no individually identifiable material in my report. Both the recording and the transcription will be stored anonymously using a code number for reference and not your name or anything that could identify you.

After the study has finished any data relating to the study will be stored securely for ten years by University of Southampton. After this period the Ministry of Defence will review whether it wishes to store the data securely for a further five years, or destroy it in accordance with Ministry of Defence policy. All information will be entirely confidential.

What will happen to the results of the research?
The results should help create a detailed description of how Army life impacts on the decision to call the out-of-hours service. This could be used to help civilian nurses and doctors to gain a greater understanding of the challenges faced by Army families and what Army families expect the out-of-hours service to provide for them.

What if there is a problem or I have a complaint?
If you have a concern or a complaint about the conduct of this study you should contact the Research Office at the University of Southampton on ▮▮▮▮▮▮▮ or by emailing ▮▮▮▮▮▮▮▮▮▮▮

In the highly unlikely event of you suffering any adverse effects as a consequence of your participation in this study, you will be eligible to apply for compensation under the Ministry of Defence's 'No Fault Compensation Scheme'.

If you have any questions do not hesitate to contact me.

Thank you very much for considering taking part in this study.

Contact details of researcher:

Lizzy Bernthal
School of Health Sciences
Building 67
University of Southampton
Highfield
Southampton
SO17 1BG
Mobile telephone/text ████████████
E-mail: ████████████████

Appendix 10 Participant consent form

Lizzy Bernthal
School of Health Sciences
Building 67
University of Southampton
Highfield
Southampton
SO17 1BG
Mobile telephone/text: ████████████
E-mail: ████████████

MoDREC protocol number: 0744/129

Out-of-hours care for Army families
CONSENT FORM

Name of Researcher:
Lizzy Bernthal

Please initial in each box if you consent to each statement. If you do not consent to one or more statements please leave the box blank. Feel free to make comments.

Please initial in box

1	I confirm that I have read and understood the participant information sheet (dated xxx) for the above study and have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2	I agree to take part in the above study.	☐
3	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected and can have the tape of my conversation destroyed.	☐
4	I agree to have my discussion taped by the researcher and for notes to be taken by the researcher.	☐
5	I agree in principle to being approached in the future about taking part in further aspects of the study.	☐

COMMENTS

Participant's Statement:

I _____ agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study. I have read both the notes written above and the Participant Information Leaflet, and understand what the research study involves.

Signed   **Date**

……………………………………..   ……………………………………..

Witness Name   ……………………………………..

Signed   **Date**

……………………………………..   ……………………………………..

Researcher's Statement:

I …………………………………………….. confirm that I have carefully explained the nature, demands and any foreseeable risks of the proposed research to the participant.

Signed   **Date**

……………………………………..   ……………………………………..

19. AUTHORISING SIGNATURES

The information supplied above is to the best of my knowledge and belief accurate. I clearly understand my obligations and the rights of research participants, particularly concerning recruitment of participants and obtaining valid consent**.**

Signature of Researcher
Signed   **Date**

……………………………………..   ……………………………………..

Name and contact details of researcher:

Lizzy Bernthal
School of Health Sciences,
Building 67, University of Southampton,
Highfield,
Southampton,
SO17 1BG
Telephone/text: ███████████
E-mail: ███████████

When completed: 1 for participant
                  1 for researcher's file

List of References

Aday, L. A. and Andersen, R. M. (1974) 'A framework for the study of access to medical care', *Health Services Research*, 9 (3), pp 208-220.

Aday, L. A. and Andersen, R. M. (1981) 'Equity of access to medical care: a conceptual and empirical overview', *Medical Care*, 19 (12), pp 4-27.

Ammons, P., Nelson, J. and Wodarski, J. (1982) 'Surviving Corporate Moves: Sources of Stress and Adaption among Corporate Executive Families', *Family Relations*, 31 (2), pp 207-212.

Anant, S. S. (1967) 'Belongingness and mental health: Some research findings', *Acta Psychologica*, 26 pp 391-396.

Anderson, R., Barbara, A. and Feldman, S. (2007) 'What patients want: A content analysis of key qualities that influence patient satisfaction', *Journal of Medical Practice Management*, 22 (5), pp 255-261.

Anthony, D. (2003) 'Changing the nature of physician referral relationships in the US: the impact of managed care', *Social Science and Medicine*, 56 (10), pp 2033-2044.

Appleton, J. V. (2002) 'Critiquing approaches to case study design for a constructivist inquiry', *Qualitative Research Journal*, 2 (2), pp 80-97.

Armed Forces (2011) *The Management of Defence*. London: Ministry of Defence.

Avis, M., Bond, M. and Arthur, A. (1997) 'Questioning patient satisfaction: An empirical investigation in two outpatient clinics', *Social Science and Medicine*, 44 (1), pp 85-92.

Aylin, P., Majeed, F. A. and Cook, D. G. (1996) 'Home visiting by general practitioners in England and Wales', *British Journal of Medicine*, 313 (7051), pp 207-210.

Baumeister, R. F. and Leary, M. R. (1995) 'The need to belong: desire for interpersonal attachments as a fundamental human motivation', *Psychological Bulletin*, 117 (3), pp 497-529.

Benzeval, M. (1998) 'The self-reported health status of lone parents', *Social Science and Medicine*, 46 (10), pp 1337-1353.

Blount, B. W., Curry A. and Lubin G. I. (1992) 'Family separations in the military', *Military Medicine*, 157 (2), pp 76-80.

Booth, B., Segal, M.W., Bell, D.B., Martin, J.A., Ender ,M.G., Rohall, D.E. and Nelson ,J. (2007) *What We Know About Army Families: 2007 Update*. Washington: Caliber.

Boss, P. (1999) 'Insights: ambiguous loss: living with frozen grief', *The Harvard Mental Health Letters*, 16 (5), pp 4-6.

Boss, P. (2002) 'Ambiguous loss in families of the missing', *Lancet*, 360 Supplement pp 39-40.

Boss, P. (2004) 'Ambiguous loss research, theory and practice: Reflections after 9/11', *Journal of Marriage and the Family*, 66 (3), pp 551-666.

Boss, P. (2006) *Loss, trauma and resilience: Therapeutic work with ambiguous loss.* New York: W.W. Norton.

Boss, P. (2007) 'Ambiguous Loss Theory: Challenges for Scholars and Practitioners', *Family Relations*, 56 (2), pp 105-111.

Bowlby, J. (1960) 'Separation anxiety', *International Journal of Psychoanalysis*, 41 pp 89-113.

Bowlby, J. (1998) *Attachment and loss*. London: Pimlico.

Bradley, E. H., Curry, L. A., and Devers, K. J. (2007) 'Qualitative data analysis for health services research: developing taxonomy, themes, and theory', *Health Services Research*, 42 (4), pp 1758-1772.

Bretherton, I. (1992) 'The origins of attachment theory: John Bowlby and Mary Ainsworth', *Developmental Psychology*, 28 (5), pp 759-775.

Brett, J.M., Stroh, L.K. and Reilly, A.H. (1992) 'Job transfer', in Cooper, C.L .and Roberson, I.T. *International review of industrial and organisational psychology* Chichester: Wiley, pp 323-362.

Brink-Muinen, A., van Dulmen, A. M., Jung H. P., and Bensing J. M. (2007) 'Do our talks with patients meet their expectations?', *Journal of Family Practice*, 56 pp 559-568.

British Medical Association (2010) *General Practitioners: out-of-hours cover.* London: British Medical Association.

Broadhurst, K. (2003) 'Engaging parents and carers with family support services: What can be learned from research on help-seeking?', *Child and Social Work*, 8 (4), pp 341-350.

Bromley, D. B. (1986) *The case-study method in psychology and related disciplines.* Chichester: Wiley.

Brown, R. T., Wiener, L., Kupst, M. J. and Brennan, T. (2008) 'Single Parents of Children with Chronic Illness: An Understudied Phenomenon', *Journal of Pediatric Psychology*, 33 (4), pp 408-421.

Bruce, S. (2010) *111 number goes live.* Available at: http://www.ehi.co.uk/news/primary-care/6166 (Accessed 20 August 10).

Bruijnzeels, M. A., Foets, M., van der Wouden, J. C., Van den Heuvel, W. J. A. and Prins, A. (1998) 'Everyday symptoms in childhood: occurrence and general practitioner consultation rates', *British Journal of General Practice*, 48 (426), pp 880-884.

Bryman, A. (2004) *Social research methods.* 2nd edn. Oxford: Oxford University Press.

Buck, A., Pleasence P., Balemer N., O'Grady A., and Genn, H. (2004) 'Lone Parents and Civil Law: Their Experience of Problems and Their Advice-seeking Behaviour', *Social Policy and Administration*, 38 (3), pp 253-269.

Bunn, F., Byrne, G. and Kendall, S. (2004) 'Telephone consultation and triage: effects on health care use and patient satisfaction', *Cochrane Collaboration*, 4 (3), pp 1-37.

Bunn, F., Byrne, G. and Kendall, S. (2005) 'The effects of telephone consultation and triage on health care use and patient satisfaction: a systematic review', *British Journal of General Practice*, 55 (521), pp 956-961.

Caldow, J., Bond, C., Ryan, M., Campbell, N.C., Miguel, F.S., Kiger, A. and Lee, A. (2007) 'Treatment of minor illness in primary care: a national survey of patient satisfaction, attitudes and preferences regarding a wider nursing role', *Health Expectations*, 10 (1), pp 30-45.

Caldwell, T.M., Caldwell, T.M., Jorm, A.F., Knox, S., Braddock, D., Dear, K.B.G. and Britt, H. (2004) 'General practice encounters for psychological problems in rural, remote and metropolitan areas in Australia', *Australian and New Zealand Journal of Psychiatry*, 38 (10), pp 774-780.

Callery, P. (1997) 'Maternal knowledge and professional knowledge: co-operation and conflict in the care of sick children', *International Journal of Nursing Studies*, 34 (1), pp 27-34.

Calnan, M., Payne, S., Kemple, T., Rossdale, M. and Ingram J. (2007) 'A qualitative study exploring variations in GPs' out-of-hours referrals to hospital', *British Journal of General Practice*, 57 (542), pp 706-713.

Campbell, S. M. and Roland, M. O. (1996) 'Why do people consult the doctor?', *Family Practice*, 13 (1), pp 75-83.

Campbell, N. C., Elliott, A. M., Sharp L., Ritchie, L. D., Cassidy J. and Little, J. (2000) 'Rural factors and survival from cancer: Analysis of Scottish cancer registrations', *British Journal of Cancer*, 82 pp 1863-1866.

Campbell, N. C., Iversen L., Farmer, J., Guest, C., and MacDonald, J. (2006) 'A qualitative study in rural and urban areas on whether--and how--to consult during routine and out of hours', *British Medical Council Family Practice*, 7 (26), pp 1-9.

Campbell, J. L., Dickens, A., Richards, S. H., Pound, P., Greco M., and Bower, P. (2007) 'Capturing users' experience of UK out-of-hours primary medical care: piloting and psychometric properties of the Out-of-hours Patient Questionnaire', *Quality and Safety in Health Care*, 16 (6), pp 462-468.

Campbell, J., Roland, M., Richards, S., Dickens, A., Greco, M., and Bower, P. (2009) 'Users' reports and evaluations of out-of-hours health care and the UK national quality requirements: a cross sectional study', *British Journal of General Practice*, 59 (558), pp e8-15.

Carver, C. S., Scheier M. F., and Weintraub J. K. (1989) 'Assessing coping strategies: a theoretically based approach', *Journal of Personality and Social Psychology*, 56 (2), pp 267-283.

Carver, C. S. and Connor-Smith J. (2010) 'Personality and coping', *Annual Review of Psychology*, 61 pp 679-704.

Chalder, M., Montgomery, A., Hollinghurst, S., Cooke, M., Munro, J., Lattimer,V., Sharp,D. and Salisbury, C. (2007) 'Comparing care at walk-in centres and at accident and emergency departments: an exploration of patient choice, preference and satisfaction', *Emergency Medicine Journal*, 24 (4), pp 260-264.

Chandra, A., Jaycox, L., Tanielian, T., Burns, R., Ruder, T. and Han, B. (2010) 'Children on the Home front: The Experience of Children from Military Families', *Pediatrics*, 125 (1), pp 16-25.

Chang, A.B., Landau, L.I., van Asperen, P.P., Glasgow, N.J., Robertson, C.F., Marchant, J.M and Mellis, C.M. (2006) 'Cough in children: definitions and clinical evaluation - Position statement of the Thoracic Society of Australia and New Zealand', *Medical Journal of Australia*, 184 (8), pp 398-403.

Charles, C., Gafni, A. and Whelan T. (1997) 'Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango)', *Social Science and Medicine*, 44 (5), pp 681-692.

Chew-Graham, C. A., May, C. R. and Perry, M. S. (2002) 'Qualitative research and the problem of judgement: lessons from interviewing fellow professionals', *Family Practice*, 19 (3), pp 285-289.

Choenarom, C., Williams, R. A. and Hagerty, B. M. (2005) 'The role of sense of belonging and social support on stress and depression in individuals with depression', *Archives of Psychiatric Nursing*, 19 (1), pp 18-29.

Christensen, M. B. and Olesen, F. (1998) 'Out of hours service in Denmark: evaluation five years after reform', *British Medical Journal*, 316 (7143), pp 1502-1505.

Christensen, M.B., Christensen, B., Mortensen, J., and Olesen, F. (2004) 'Intervention among frequent attenders of the out-of-hours service: a stratified cluster randomized controlled trial', *Scandinavian Journal of Primary Health Care*, 22 (3), pp 180-186.

Clark, T. (2010) 'On 'being researched': Why do people engage with qualitative research?', *Qualitative Research* 10 (4), pp 399-419.

Clifton, G. (2007) *The Experience of Education of the Army Child.* PhD Thesis. Oxford Brookes University.

Coleman, J. (2009) *A history of cant and slang dictionaries*. Oxford: Oxford University Press.

Commission for Rural Communities (2010) *State of the countryside 2010: Living in the countryside* Available at: http://ruralcommunities.gov.uk/files/sotc/livingincountryside.pdf (Accessed 24 January 11).

Cornford, C., Morgan, M. and Ridsdale L. (1993) 'Why do Mothers Consult when their Children Cough?', *Family Practice*, 10 (2), pp 193-196.

Cozza, S., Chun R. and Polo J. (2005) 'Military Families and Children during Operation Iraqi Freedom', *Psychiatric Quarterly*, 76 (4), pp 371-378.

Creswell, J. W. (2007) *Qualitative inquiry & research design: Choosing among five approaches.* 2nd edn. Thousand Oaks: Sage Publications.

Creswell, J. W., (2009) *Research design: Qualitative, quantitative, and mixed method approaches.* 3rd edn. Los Angeles: Sage Publications.

Crocetti, M., Moghbeli, N. and Serwint, J. (2001) 'Fever phobia revisited: have parental misconceptions about fever changed in 20 years?', *Pediatrics*, 107 (6), pp 1241-1246.

Cunningham-Burley, S., Backett-Milburn, K. and Kemmer, D. (2006) 'Constructing health and sickness in the context of motherhood and paid work', *Sociology of Health and Illness*, 28 (4), pp 385-409.

Dandeker, C., French, C., Birtles, C. and Wessly S. (2006) 'Deployment Experiences of British Army Wives Before, During and After Deployment: Satisfaction with Military Life and Use of Support Networks' In: NATO, *NATO Conference: Human Dimensions in Military Operations– Military Leaders' Strategies for Addressing Stress and Psychological Support,* Neuilly-sur-Seine, France, 8th-10th April 2006. pp 381-401 Available at:
http://ftp.rta.nato.int/public/PubFullText/RTO/MP/RTO-MP-HFM-134/MP-HFM-134-38.pdf (Accessed 9 February 11).

Davis, J., Ward, D. B. and Storm, C. (2011). 'The Unsilencing of Military Wives: Wartime Deployment Experiences and Citizen Responsibility'. *Journal of Marital and Family Therapy* 37 (1), pp 51-66.

Defence Analytical Services Agency (2008a) *UK Defence Statistics 2007: Strength, Intake & Outflow of UK Regular Forces.* London: Defence Analytical Services Agency.

Defence Analytical Services Agency (2008b) *UK Regular Forces Stationed Locations*. London: Defence Analytical Services Agency.

Defence Analytical Services and Advice (2010) 'Health' in Defence Analytical Services and Advice, (2010) *UK Defence Statistics 2010.* London: Defence Analytical Services Agency, pp 108-146. Available at:
http://www.dasa.mod.uk/modintranet/UKDS/UKDS2010/c3/table302.php
(Accessed 20 February 11).

Defence Analytical Services Agency (2011a) *UK Defence Statistics 2010: Glossary* London: Defence Analytical Services Agency. Available at: http://www.dasa.mod.uk/modintranet/UKDS/UKDS2010/glossary.php (Accessed 25 March 11).

Defence Analytical Services Agency (2011b) *UK Defence Statistics 2010: Table 2.12 Strength of UK Regular Forces by sex and Service at 1 April each year*. London: Defence Analytical Services Agency. Available at: http://www.dasa.mod.uk/modintranet/UKDS/UKDS2010/chapter2.php (Accessed 11 March 11).

Defence News (2007) *Kids benefit from Storybook Soldiers scheme*'. Available at: http://webarchive.nationalarchives.gov.uk/+/http://www.mod.uk/defenceinternet/defencenews/peopleindefence/kidsbenefitfromstorybooksoldiersscheme.html (Accessed 8 February 11).

Denscombe, M. (2007) *The good research guide for small-scale social research projects.* 3rd ed. Maidenhead: Open University Press.

Denzin, N. K. and Lincoln, Y. S. (2005) *The Sage handbook of qualitative research.* 3rd edn. Thousand Oaks: Sage Publications.

Denzin, N. K. and Lincoln, Y. S. (2008) *Strategies of qualitative inquiry.* 3rd edn. London: Sage Publications.

Department of Defense (2011) The US Department of Defense. Available at: http://www.defense.gov/ (Accessed 11 October 11).

Department of Health (1997) *The New NHS Modern, Dependable*. London: Department of Health.

Department of Health (1999) *Making a difference: strengthening the nursing, midwifery and health visitor contribution to health and health care*. London: Department of Health.

Department of Health (2004a) *National Quality Requirements in the Delivery of Out-of-Hours Services*. London: Department of Health.

Department of Health (2004b) *National standards for better health*. London: The Stationary Office.

Department of Health (2007) *Making it better: For children and young people*. London: Department of Health.

Department of Health (2010a) *Handbook to the NHS Constitution*. London: The Stationary Office.

Department of Health (2010b) *Your choice of GP practice: A consultation on how to enable people to register with the GP practice of their choice*. London: Department of Health.

Department of Health (2010c) *Equity and excellence: Liberating the NHS*. London: The Stationary Office.

Department of Health (2011) *Liberating the NHS: Legislative framework and next steps*. London: The Stationary Office.

Director General Army Medical Services (2009) *Annual Report on the Health of the Army 2008*. Camberley: Ministry of Defence.

Diversity Training University International (2008) *Cultural Diversity Glossary of Terms*. San Francisco: Diversity Training University International Publications Division.

Dykstra, P. (2009) 'Older adult loneliness: myths and realities', *European Journal of Ageing*, 6 (2), pp 91-100.

Eadie, C. (2010) 'Storybook soldiers'. *Families Journal* (Summer), pp 6-7.

Edwards, A., Egbunike, J., Bale, S., Bowden, S. and Button, L. (2009) *Identifying service improvements for primary care provision: evaluating patient and carer experiences of using "out-of-hours" services*. Cardiff: Cardiff University.

Elwyn, G., Edwards, A., Gwyn, R. and Grol, R. (1999) 'Towards a feasible model for shared decision-making: focus group study with general practice registrars', *British Medical Journal*, 319 (7212), pp 753-756.

Elwyn, G., Edwards, A., Kinnersley, P. and Grol, R. (2000) 'Shared decision-making and the concept of equipoise: the competences of involving patients in healthcare choices', *British Journal of General Practice*, 50 (460), pp 892-899.

Elwyn, G., Edwards, A., Wensing, M., Hibbs, R., Wilkinson C. and Grol R. (2001) 'Shared decision-making observed in clinical practice: visual displays of communication sequence and patterns', *Journal of Evaluation in Clinical Practice*, 7 (2), pp 211-221.

Farmer, J., Lauder, W., Richards, H. and Sharkey S. (2003) 'Dr. John has gone: assessing health professionals' contribution to remote rural community sustainability in the UK', *Social Science and Medicine*, 57 (4), pp 673-686.

Farmer, J., Iversen, L., Campbell, N.C., Guest, C., Chesson, R., Deans, G. and MacDonald,J. (2006) 'Rural/urban differences in accounts of patients' initial decisions to consult primary care', *Health and Place*, 12 (2), pp 210-221.

Fernandez-Pol, B. (1988) 'Does the military family syndrome exist?' *Military Medicine*, 153 (8), pp 418-420.

Field, K. S. and Briggs, D. J. (2001) 'Socio-economic and locational determinants of accessibility and utilization of primary health-care', *Health Social Care Community*, 9 (5), pp 294-308.

Fisher, C. D. and Shaw, J. B. (1994) 'Relocation Attitudes and Adjustment: A Longitudinal Study', *Journal of Organisational Behavior*, 15 (3), pp 209-224.

Fitzsimons, V. M. and Krause-Parello, C. A. (2009). 'Military Children: When Parents Are Deployed Overseas'. *The Journal of School Nursing* 25 ([1), pp 40-47.

Fontana, A. and Frey, J. H. (2008) 'The Interview: From neutral stance to Political Involvement', in Denzin, N. K. and Lincoln, Y. S., (2008) *Collecting and interpreting qualitative materials.* 3rd edn. London: Sage Publications, pp 115-161.

Foster, J., Jessopp, L. and Chakraborti, S. (2003) 'Do callers to NHS Direct follow the advice to attend an accident and emergency department?', *Emergency Medicine Journal*, 20 (3), pp 285-288.

Fry, M. M. (2009) 'Barriers and facilitators for successful after hours care model implementation: Reducing ED utilisation', *Australasian Emergency Nursing Journal*, 12 (4), pp 137-144.

Galahad SMS Ltd (2007) *Prevention of Drug Misuse in the Army: Phase II Report*. London: Ministry of Defence.

Garratt, A. M., Danielsen, K., Forland, O. and Hunskaar, S. (2010) 'The Patient Experiences Questionnaire for Out-of-Hours Care (PEQ-OHC): data quality, reliability, and validity', *Scandinavian Journal of Primary Health Care*, 28 (2), pp 95-101.

Gerard,K., Lattimer,V., Surridge,H., George,S., Turnbull,J., Burgess,A., Lathlean,J. and Smith,H. (2006) 'The introduction of integrated out-of-hours arrangements in England: a discrete choice experiment of public preferences for alternative models of care', *Health Expectations*, 9 (1), pp 60-69.

Gerard, K., Salisbury, C., Street, D., Pope, C. and Baxter, H. (2008) 'Is fast access to general practice all that should matter? A discrete choice experiment of patients' preferences', *Journal of Health Services Research Policy*, 13 (suppl 2), pp 3-10.

Giesen, P., Charante, E. M., Mokkink, H., Bindels, P., van den B. W., and Grol, R. (2007a) 'Patients evaluate accessibility and nurse telephone consultations in out-of-hours GP care: determinants of a negative evaluation', *Patient Education and Counseling*, 65 (1), pp 131-136.

Giesen, P., van, L. N., Mokkink, H., van den, B. W., and Grol R. (2007b) 'General practice cooperatives: long waiting times for home visits due to long distances? 1028', *BMC Health Services Research.* (7):19 Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1804268/ (Accessed 11 February 11).

Giles, S. (2005) 'Army dependents: childhood illness and health provision', *Community Practitioner*, 78 (6), pp 213-217.

Glaser, B. G. and Strauss, A. L. (1967) *Discovery of Grounded Theory: Strategies for Qualitative Research*. Cambridge: Cambridge University Press.

Glick, P. (2009) 'How reliable are surveys of client satisfaction with healthcare services? Evidence from matched facility and household data in Madagascar', *Social Science and Medicine*, 68 (2), pp 368-379.

Goddard, M. and Smith, P. (2001) 'Equity of access to health care services: Theory and evidence from the UK', *Social Science and Medicine*, 53 (9), pp 1149-1162.

Grbich,C. (2007) *Qualitative data analysis: an introduction.* London: Sage

Griffiths, J. D., Stewart, L. S. and Cato, E. D. (1987) *Annual Survey of Army Families: A Report on Army Spouses and Families in 1987*. Alexandria: US Army Community and Family Support Center.

Grundy-Wheeler, N. J. (1991) 'Out of hours attendance in an Army practice', *British Journal of General Practice*, 41 (346), pp 210-212.

Guba, E. G. and Lincoln, Y. S. (2008) 'Paradigmatic Controversies, Contradictions and Emerging Confluences', in Denzin, N. K. and Lincoln, Y. S. (2008) *The landscape of qualitative research.* 3rd edn. London: Sage Publications, pp 255-286.

Gulliford, M. Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R. and Hudson, M. (2002) 'What does 'access to health care' mean?', *Journal of Health Services and Research Policy*, 7 (3), pp 186-188.

Hagerty, B. M., Lynch-Sauer, J., Patusky, K. L., Bouwsema, M. and Collier P. (1992) 'Sense of belonging: a vital mental health concept', *Archives of Psychiatric Nursing,* 6 (3), pp 172-177.

Hansen, E. H., Zakariassen, E. and Hunskaar S. (2009) 'Sentinel monitoring of activity of out-of-hours services in Norway in 2007: an observational study', *BMC Health Services Research*, 9. p 123 Available at: http://www.biomedcentral.com/content/pdf/1472-6963-9-123.pdf (Accessed 11 February 11).

Hart, C., (2004) *Doing a literature search: a comprehensive guide for the social sciences.* London: Sage Publications.

Healy, J. and McKee, M. (2004) *Accessing Health Care: Responding to Diversity.* Oxford: Oxford University Press.

Heaney, D. J. and Gorman D. R. (1996) 'Auditing out-of-hours primary medical care', *Health Bulletin*, 54 (6), pp 495-498.

Hendry, S. J., Beattie, T. F. and Heaney, D. (2005) 'Minor illness and injury: factors influencing attendance at a paediatric accident and emergency department', *Archives of Disease in Childhood*, 90 (6), pp 629-633.

HM Government (2010a) *Securing Britain in an Age of Uncertainty: The Strategic Defence and Security Review*. London: The Stationary Office.

HM Government (2010b) *What is the Government doing for the members of the Armed Forces*? London: The Stationary Office.

Hogg, M., Terry, D.J. and White, K. M. (1995) 'A Tale of Two Theories: A Critical Comparison of Identity Theory with Social Identity,' *Theory Social Psychology Quarterly,* 58 (4), pp 255-269.

Holloway, I. and Wheeler, S. (2010) *Qualitative research in nursing and healthcare.* 3rd edn. Chichester: Wiley-Blackwell.

Hopton, J., Hogg, R., and McKee, I. (1996) 'Patients' accounts of calling the doctor out of hours: qualitative study in one general practice', *British Medical Journal*, 313 (7063), pp 991-994.

Horrocks, S., Anderson, E., and Salisbury, C. (2002) 'Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors', *British Medical Journal*, 324 (7341), pp 819-823.

House of Commons Foreign Affairs Committee (2006) *Foreign Policy Aspects of the War against Terrorism*. London: The Stationary Office. Available at: http://www.publications.parliament.uk/pa/cm200506/cmselect/cmfaff/573/573.pdf (Accessed 5 March 11).

House of Commons Defence Committee (2008) *Defence - Seventh Report: Medical care for the Armed Forces.* London: The Stationary Office.

Houston, A. and Pickering, A. (2000) ''Do I or don't I call the doctor'; a qualitative study of parental perceptions of calling the GP out-of-hours', *Health Expectations*, 3 (4), pp 234-242.

Huebner, A. J., Mancini, J. A., Wilcox, R. M., Grass, S. R. and Grass G. A. (2007) 'Parental Deployment and Youth in Military Families: Exploring Uncertainty and Ambiguous Loss', *Family Relations*, 56 (2), pp 112-122.

Hugenholtz, M., Broer, C. and van Daalen, R. (2009) 'Apprehensive parents: a qualitative study of parents seeking immediate primary care for their children', *British Journal of General Practice*, 59 (560), pp 173-179.

International Council on Security and Development (2010) *Operation Moshtarak: Lessons Learned The Network of European Foundations*. London: The International Council on Security and Development.

Irvine, S. and Cunningham-Burley, S. (1991) 'Mothers' concepts of normality, behavioural change and illness in their children', *British Journal of General Practice*, 41 (350), pp 371-374.

Jolly, R. A. (1987) *Military man, family man crown property?* London: Brassey.

Jones, A. P., Bentham, G., Harrison, B. D., Jarvis, D., Badminton, R. M., and Wareham N. J. (1998) 'Accessibility and health service utilization for asthma in Norfolk, England', *Journal of Public Health Medicine*, 20 pp 312-317.

Jordan, H., Roderick, P., Martin, D., and Barnett, S. (2004) 'Distance, rurality and the need for care: access to health services in South West England', *International Journal of Health Geographics*, 3 (1), p 21.

Kai, J. (1996a) 'Parents' difficulties and information needs in coping with acute illness in preschool children: a qualitative study', *British Medical Journal*, 313 (7063), pp 987-990.

Kai, J. (1996b) 'What worries parents when their preschool children are acutely ill, and why: a qualitative study', *British Medical Journal*, 313 (7063), pp 983-986.

Kallestrup, P. and Bro, F. (2003) 'Parents' beliefs and expectations when presenting with a febrile child at an out-of-hours general practice clinic', *British Journal of General Practice*, 53 (486), pp 43-44.

Keeble, R. (2010) 'Operation Moshtarak and the manufacture of credible, "heroic" warfare', in Keeble, R. and Mair, J. (2010) *Afghanistan, War and the Media: Deadlines and Frontlines.* Bury St Edmunds: Arima Publishing, pp 206-229.

Kirschenbaum, A. and Weisberg, J. (2002) 'Employee's Turnover Intentions and Job Destination Choices', *Journal of Organisational Behavior*, 23 (1), pp 109-125.

Kitzinger, J. (1995) 'Qualitative Research: Introducing focus groups', *British Medical Journal*, 311 (7000), pp 299-302.

Kitzinger, J. (2006) 'Focus groups', in Pope, C. M. N., (2006) *Qualitative Research in Healthcare.* 3rd edn. London: BMJ books, pp 21-31.

Kobasa, S. C., Maddi, S. R., Puccetti, M. C. and Zola, M. A. (1994) 'The effects of the resistance resources of personality hardiness, exercise, and social support', in Steptoe, A. and Wardle, J., (1994) *Psychosocial processes and health: a reader.* Cambridge: Cambridge University Press, pp 247-260.

Krueger, R. A. and Casey, M. A. (2000) *Focus groups: a practical guide for applied research.* London: Sage Publications.

Kubler-Ross, E., Wessler S., and Avioli L. V. (1972) 'On death and dying', *Journal of the American Medical Association*, 221 (2), pp 174-179.

Kvale, S. and Brinkmann, S. (2009) 'Epistemological Issues of Interviewing', in Kvale, S. and Brinkmann, S., (2009) *InterViews Learning the craft of qualitative research interviewing.* 2nd edn. Los Angeles: Sage Publications, pp 47-60.

LaGrone, D. M. (1978) 'The military family syndrome', *American Journal of Psychiatry*, 135 (9), pp 1040-1043.

LaGrone, D. M. (1982) 'More on the military family syndrome', *American Journal of Psychiatry*, 139 (1), pp 133-134.

Last, J. M. (1963) 'The iceberg: completing the clinical picture in general practice'. *Lancet* 2, pp 28-31.

Lattimer, V., George, S., Thompson, F., Thomas, E., Mullee, M., Turnbull, J., Smith, H., Moore, M., Bond, H. and Glasper, A. (1998) 'Safety and effectiveness of nurse telephone consultation in out of hours primary care: randomised controlled trial', *British Medical Journal*, 317 (7165), pp 1054-1059.

Lattimer, V. Sassi, F., George, S., Moore, M., Turnbull, J., Mullee, M. and Smith, H. (2000) 'Cost analysis of nurse telephone consultation in out of hours primary care: evidence from a randomised controlled trial', *British Medical Journal*, 320 (7241), pp 1053-1057.

Lattimer, V., Turnbull, J., Burgess, A., Surridge, H, Gerard, Lathlean, J., Smith, H. and George,S. (2005) 'Effect of introduction of integrated out of hours care in England: observational study', *British Medical Journal*, 331 (7508), pp 81-84.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R. and Sibbald, B. (2005) 'Substitution of doctors by nurses in primary care', Cochrane Database of Systematic Reviews (2), p CD001271. Available at: http://www.google.co.uk/#sclient=psy&hl=en&rlz=1R2GZHY_enGB373&q=%27Substitution+of+doctors+by+nurses+in+primary+care%27&aq=&aqi=&aql=&oq=&pbx=1&fp=5448f8496853e3d0 (Accessed 18 August 10).

Lazarus, R. S. (2006) 'Emotions and interpersonal relationships: toward a person-centered conceptualization of emotions and coping', *Journal of Personality*, 74 (1), pp 9-46.

Leach, J., Ridsdale, L. and Smeeton, N. (1993) 'Is there a relationship between a mother's mental state and consulting the doctor by the family? A study in a military general practice', *Family Practice*, 10 (3), pp 305-311.

Leader of the Opposition's Military Covenant Commission (2008) *The Health of the Covenant: An Interim Paper (unpublished)*. Available at: http://www.google.co.uk/#sclient=psy&hl=en&site=&source=hp&q=The+Health+of+the+Covenant:+An+Interim+Paper+&rlz=1R2GZHY_enGB373&aq=&aqi=&aql=&oq=&pbx=1&fp=5448f8496853e3d0 (Accessed 18 May 09).

Lee, I., Lee, E. O., Kim, H. S., Park, Y. S., Song, M. and Park Y. H. (2004) 'Concept development of family resilience: a study of Korean families with a chronically ill child', *Journal of Clinical Nursing*, 13 (5), pp 636-645.

Leibowitz, R., Day S. and, Dunt D. (2003) 'A systematic review of the effect of different models of after-hours primary medical care services on clinical outcome, medical workload, and patient and GP satisfaction', *Family Practice*, 20 (3), pp 311-317.

Leventhal, H., Watts, J. C., and Pagano, F. (1967) 'Effects of fear and instructions on how to cope with danger', *Journal of Personality and Social Psychology*, 6 (3), pp 313-321.

Leventhal, H., Safer, M. A., and Panagis, D. M. (1983) 'The impact of communications on the self-regulation of health beliefs, decisions, and behavior', *Health Education Quarterly*, 10 (1), pp 3-29.

Leventhal, H., Leventhal, E. A. and Contrada, R. J. (1998) 'Self-regulation, health, and behavior: A perceptual-cognitive approach', *Psychology and Health*, 13 (4), pp 717-733.

Leventhal, H., Bissette, I. and Leventhal, E. A. (2003) 'The common sense model of self-regulation of health and illness', in Cameron, L. D. and Leventhal, H., (2003) *The self-regulation of health and illness behaviour.* London: Routledge, pp 42-65.

Levett-Jones, T. and Lathlean, J. (2008) 'Belongingness: a prerequisite for nursing students' clinical learning', *Nurse Education Practice*, 8 (2), pp 103-111.

Levett-Jones, T. and Lathlean, J. (2009) 'The ascent to competence conceptual framework: an outcome of a study of belongingness', *Journal of Clinical Nursing*, 18 (20), pp 2870-2879.

Liljegren, M. and Ekberg, K. (2008) 'The longitudinal relationship between job mobility, perceived organisational justice, and health', *BMC Public Health*, 8 (164), pp 1-10. Available at:
http://www.biomedcentral.com/content/pdf/1471-2458-8-164.pdf (Accessed 24 March 11).

Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic inquiry*. Newbury Park: Sage.

Lincoln, Y. S. and Guba, E. G. (2000) 'Paradigmatic controversies, contradictions and emerging confluences', in Denzin, N. K. and Lincoln, Y. S., (2000) *Handbook of qualitative research.* 2ⁿᵈ edn. London: Sage Publications, pp 163-188.

Link, B. G. and Phelan, J. C. (2001) 'Conceptualizing Stigma', *Annual Review of Sociology*, 27 (1), pp 363-385.

Lovett, A., Haynes, R., Sunnenberg, G. and Gale S. (2002) 'Car travel time and accessibility by bus to general practitioner services: a study using patient registers and GIS', *Social Science and Medicine*, 55 (1) pp 97-111.

Maslow, A. H. (1987) *Motivation and personality*. New York: Harper & Row.

Matthiesen, J. K. and Tissington, P. (2008) 'The Four-Factor Taxonomy of Relocation Outcomes', *Human Resource Development Review*, 7 (2), pp 142-164.

Mattlin, J. A., Wethington, E. and Kessler R. C. (1990) 'Situational determinants of coping and coping effectiveness', *Journal of Health and Social Behavior*, 31 (1), pp 103-122.

McCubbin, H.I. ., Joy, C. B., Cauble, A. E., Comeau, J. K., Patterson J. M. and Needle R. H. (1980) 'Family Stress and Coping: A Decade Review', *Journal of Marriage and the Family*, 42 (4), pp 855-871

McKinley, R. K. and Roberts, C. (2001) 'Patient satisfaction with out of hours primary medical care', *Quality and Safety in Health Care*, 10 (1), pp 23-28.

McKinley, R. K., Stevenson, K., Adams S. and Manku-Scott, T. (2002) 'Meeting patient expectations of care: the major determinant of satisfaction with out-of-hours primary medical care?', *Family Practice*, 19 (4), pp 333-338.

McMenemy, P. (2001) *Going Sick- Soldiers Speak About Health and Illness.* MSc Thesis. United Medical and Dental Schools of Guys and St Thomas's Hospitals.

Mechanic, D. (1964) 'The influence of mothers on their children's health attitudes and behavior', *Pediatrics*, 33 (3), pp 444-453.

Mellor, D., Stokes, M., Firth, L., Hayashi Y. and Cummins, R. (2008) 'Need for belonging, relationship satisfaction, loneliness, and life satisfaction', *Personality and Individual Differences*, 45 (3), pp 213-218.

Meningitis Research Foundation (2009) *Race Against Time.* Bristol: Meningitis Research Foundation. Available at: http://www.meningitis.org/assets/x/51490 (Accessed 24 February 11).

Meyer-Weitz, A., Reddy, P., Van Den Borne, H. W., Kok, G., and Pietersen J. (2000a) 'Health care seeking behaviour of patients with sexually transmitted diseases: determinants of delay behaviour', *Patient Education and Counseling*, 41 (3), pp 263-274.

Meyer-Weitz, A., Reddy, P., Van Den Borne, H. W., Kok, G. and Pietersen J. (2000b) 'The determinants of health care seeking behaviour of adolescents attending STD clinics in South Africa', *Journal of Adolescents*., 23 (6), pp 741-752.

Miles, M. B. and Huberman, A. M. (1994) *Qualitative data analysis: an expanded sourcebook*. Thousand Oaks, California: Sage Publications.

Ministry of Defence (2000) *Soldiering - The Military Covenant (Army Doctrine Publication Volume 5) GD&D/18/34/71 Army Code No 71642.* London: Ministry of Defence.

Ministry of Defence (2004) *Army Primary Health Care Services*. London: Ministry of Defence.

Ministry of Defence (2005) *Soldier, welfare and family*. London: Ministry of Defence.

Ministry of Defence (2006) *Ministry of Defence Research Ethics Committee* (*MoDREC) Researcher Guide.* London: Ministry of Defence.

Ministry of Defence (2007) *Soldiering: The Military Covenant: Chapter 1-2*. London: Ministry of Defence. Available at: http://www.army.mod.uk/servingsoldier/usefulinfo/valuesgeneral/adp5milcov/ss_hrpers_values_adp5_1_w.html#backgrd (Accessed 18 March 11).

Ministry of Defence (2008a) *The Army Family.* London: Ministry of Defence.

Ministry of Defence (2008b) *Values and Standards of the British Army*. London: Ministry of Defence. Available at: http://www.google.co.uk/#sclient=psy&hl=en&site=&source=hp&q=Values+and+Standards+of+the+British+Army.+&rlz=1R2GZHY_enGB373&aq=&aqi=&aql=&oq=&pbx=1&fp=5448f8496853e3d0 (Accessed 9 February 11).

Ministry of Defence (2009) *Guide for Families of deployed Regular Army Personnel.* London: Ministry of Defence. Available at: http://www.mod.uk/NR/rdonlyres/77783C01-E4D3-4487-BCA5-7CD656D7D645/0/Fam_guide_Apr_09_WEB2.pdf (Accessed 24 March 11).

Ministry of Defence (2010a) *The Future Character of Conflict*. London: Ministry of Defence.

Ministry of Defence (2010b) *The Army: An introduction.* London: Ministry of Defence. Available at: http://www.army.mod.uk/documents/general/2010_ARMY_Brochure_9.0_(2).pdf (Accessed 11 March 11).

Ministry of Defence (2010c) *A guide for the families of mobilised members of the Territorial Army and the Regular Reserve*. London: Ministry of Defence.

Ministry of Defence (2010d) *Equality and Diversity*. London: Ministry of Defence.

Ministry of Defence (2011a) *Transforming Defence - the most significant reform for a generation.* London: Ministry of Defence. Available at: http://www.mod.uk/DefenceInternet/DefenceNews/DefencePolicyAndBusiness/TransformingDefenceTheMostSignificantReformForAGeneration.htm (Accessed 3 March 11).

Ministry of Defence (2011b) *Defence for the Service Community: SFA [Services Family Accommodation] Entitlement.* London: Ministry of Defence.

Ministry of Defence (2011c) *Uniform to work day.* London: Ministry of Defence. Available at: http://www.army.mod.uk/news/24421.aspx (Accessed 29 Sep 11).

Ministry of Defence (2011d) *Armed Forces Covenant.* London: Ministry of Defence. Available at: http://www.mod.uk/NR/rdonlyres/4E9E2014-5CE6-43F2-AE28-B6C5FA90B68F/0/Armed_Forces_Covenant.pdf (Accessed 9 Oct 11).

Ministry of Defence (2011e) *Strategic Defence and Security Review and Defence Reform Briefing Pack.* London: Ministry of Defence.

Moll van Charante, E. P., Drost, S., Klazinga, N. S. and Bindels P. J. (2006) 'Nurse telephone triage in out-of-hours GP practice: determinants of independent advice and return consultation', *British Medical Council Family Practice*, 7 (74), pp 1-9.

Moll van Charante, E. P., Gerben, T. R. and Bindels P. (2008) 'Self-referrals to the A&E department during out-of-hours: Patients' motives and characteristics', *Patient Education and Counseling*, 70 (2), pp 256-265.

Montalbano-Phelps, L. L. (2003) 'Discourse of Survival: Building Families Free of Unhealthy Relationships', *Journal of Family Communication*, 3 (3), pp 149-177.

Morgan, D. L. (1997) *Focus groups as qualitative research*. London: Sage Publications.

Morgan, M. (2003) 'Patients' help-seeking and access to health care', in Gulliford, M. and Morgan, M. (2003) *Access to health care.* London: Routledge, pp 61-83.

Morgan, D. L. (2006) 'Focus Groups', in Jupp, V., (2006) *The Sage Dictionary of Social Research Methods.* London: Sage Publications.

Morrice, J. K., Taylor, R. C., Clark, D. and McCann K. (1985) 'Oil wives and intermittent husbands', *British Journal of Psychiatry*, 147 pp 479-483.

Morrison, J. (1981) 'Rethinking the military family syndrome', *American Journal of Psychiatry*, 138 (3), pp 354-357.

Munro, J., Maheswaran, R., and Pearson T. (2003) 'Response to requests for general practice out of hours: geographical analysis in North West England', *Journal of Epidemiology and Community Health*, 57 (9), pp 673-674.

Munro, J., Sampson F. and Nicholl J. (2005) 'The impact of NHS Direct on the demand for out-of-hours primary and emergency care', *British Journal of General Practice*, 55 (519), pp 790-792.

Neal, R. D., Heywood, P. L., Morley S., Clayden, A. D. and Dowell A. C. (1998) 'Frequency of patients' consulting in general practice and workload generated by frequent attenders: comparisons between practices', *British Journal of General Practice*, 48 (426), pp 895-898.

Neill, S. J. (2000) 'Acute childhood illness at home: the parents' perspective', *Journal of Advanced Nursing*, 31 (4), pp 821-832.

NHS Evidence (2010) 'Critical Appraisal Skills Programme (CASP) toolkits'. Available at: http://www.library.nhs.uk/childhealth/ViewResource.aspx?resID=262636 (Accessed 8 March 10).

NHS Primary Care Commissioning (2011) *Looking after dependants of Armed Forces personnel.* Available at: http://www.pcc.nhs.uk/looking-after-dependants-of-armed-forces-personnel (Accessed 8 March 11).

O'Cathain, A., Knowles, E., Munro, J. and Nicholl J. (2007) 'Exploring the effect of changes to service provision on the use of unscheduled care in England: population surveys', *BMC Health Services Research*, 7 p 61.

O'Cathain, A., Coleman, P. and Nicholl J. (2008) 'Characteristics of the emergency and urgent care system important to patients: a qualitative study', *Journal of Health Services and Research Policy*, 13 (Suppl 2) pp 19-25.

O' Donnell, C. A., McConnachie, A., Moffat, K., Drummond, N., Wilson, P. and Ross S. (1999) 'Cross sectional study of social variation in use of an out of hours patient transport service', *British Medical Journal*, 318 (7183), pp 566-567.

Office for National Statistics (2002) *Social Trends 32*. London: The Stationery Office.

Parsons, T. (1951) *The social system.* London: Routledge.

Patton, M. Q. (2002) *Qualitative research & evaluation methods.* 3rd edn. Thousand Oaks: Sage Publications.

Payne, F., Shipman, C. and Dale J. (2001) 'Patients' experiences of receiving telephone advice from a GP co-operative', *Family Practice*, 18 (2), pp 156-160.

Peel, E., Parry, O., Douglas, M. and Lawton, J. (2006) ' "It's No Skin off My Nose": Why People Take Part in Qualitative Research', *Qualitative Health Research* 16 (10), pp 1335-1349.

Penchansky, R. and Thomas, J. W. (1981) 'The concept of access: definition and relationship to consumer satisfaction', *Medical Care*, 19 (2), pp 127-140.

Philips, H., Mahr, D., Remmen, R., Weverbergh, M., De G. D. and Van R. P. (2010) 'Experience: the most critical factor in choosing after-hours medical care', *Quality and Safety in Health Care*, 9 (1) pp 1-9. Available at: http://qualitysafety.bmj.com/content/19/6/1.2.full.pdf (Accessed 25 March 11).

Plass, A. M., Timmermans, D. R. and Wal, G. V. (2005) 'Does stimulating self-care increase self-care behaviour for minor illnesses of Dutch and Turkish inhabitants of a deprived area in The Netherlands?', *Patient Education and Counseling*, 63 (1), pp 97-103.

Pooley, C., Briggs, J., Gatrell, T., Mansfield, T., Cummings, D. and Deft J. (2003) 'Contacting your GP when the surgery is closed: issues of location and access', *Health and Place*, 9 (1), pp 23-32.

Pope, C. and Mays, N. (2006) *Qualitative Research in Health Care.* 3rd edn. London: BMJ Books.

Pratt, M. G. and Rafaeli A. (1997) 'Organisational Dress as a Symbol of Multi-layered Social Identities', *The Academy of Management Journal*, 40 (4), pp 862-898.

Prince, M. and Worth, C. (1992) 'A study of 'inappropriate' attendances to a paediatric Accident and Emergency Department', *Journal of Public Health*, 14 (2), pp 177-182.

Public Health Resource Unit (2008) 'Critical Appraisal Skills Programme (CASP)'. Available at: http://www.phru.nhs.uk/pages/PHD/resources.htm (Accessed 8 Feb 08).

Ragin, C. C. and Becker, H. S. (1992) *What is a case? Exploring the foundations of social inquiry*. Cambridge: Cambridge University Press.

Rajpar, S. F., Smith, M. A. and Cooke, M. W. (2000) 'Study of choice between accident and emergency departments and general practice centres for out of hours primary care problems', *Emergency Medicine Journal*, 17 (1), pp 18-21.

Raphael, J. L., Zhang, Y., Liu, H. and Giardino, A. P. (2010) 'Parenting stress in US families: implications for paediatric healthcare utilization', *Child Care Health and Development*, 36 (2), pp 216-224.

Rayment, S. (2009) 'Overstretch pushes British troops to the brink'. *Telegaph.co.uk* Available at:
http://www.telegraph.co.uk/news/newstopics/politics/defence/4214029/Overstretch-pushes-British-troops-to-the-brink.html (Accessed 20 January 11).

Rayment, S. (2010) 'Thousands of British troops wounded in Afghanistan'. *Telegraph.co.uk* Available at:
http://www.telegraph.co.uk/news/worldnews/asia/afghanistan/7278645/Thousands-of-British-troops-wounded-in-Afghanistan.html (Accessed 3 February 11).

Redsell, S., Jackson, C., Stokes, T., Hastings, A. and Baker, R. (2007) 'Patient expectations of 'first-contact care' consultations with nurse and general practitioners in primary care', *Quality in Primary Care*, 15 (1), pp 5-10.

Richards, H. and Emslie C. (2000) 'The 'doctor' or the 'girl from the University'? Considering the influence of professional roles on qualitative interviewing', *Family Practice*, 17 (1), pp 71-75.

Richards, S. H., Pound, P., Dickens A., Greco, M. and Campbell J. L. (2007) 'Exploring users' experiences of accessing out-of-hours primary medical care services', *Quality and Safety in Health Care*, 16 (6), pp 469-477.

Rieffe, C., Oosterveld, P., Wijkel, D. and Wiefferink C. (1999) 'Reasons why patients bypass their GP to visit a hospital emergency department', *Accident and Emergency Nursing*, 7 (4), pp 217-225.

Ritchie, J. and Lewis, J. (2003) *Qualitative research practice: A guide for Social Science Students and researchers.* London: Sage Publications.

Robbins, H., Hundley, V. and Osman L. M. (2003) 'Minor illness education for parents of young children', *Journal of Advanced Nursing*, 44 (3), pp 238-247.

Royal College of General Practitioners (2011) *The RCGP Centre for Commissioning Competency Framework*. London: Royal College of General Practitioners.

Ruston, A. (2006) 'Interpreting and managing risk in a machine bureaucracy: Professional decision-making in NHS Direct', *Health, Risk & Society*, 8 (3), pp 257-271.

Ryan, L. and Golden, A. (2006) ''Tick the Box Please': A Reflexive Approach to Doing Quantitative Social Research', *Sociology*, 40 (6), pp 1191-1200.

Ryan-Wenger, N. A. (2002) 'Impact of the threat of war on children in military families', *Journal of Pediatric Health Care*, 16 (5), pp 245-252.

Salisbury, C. (2000) 'The demand for out-of-hours care from GPs: a review', *Family Practice*, 17 (4), pp 340-347.

Salisbury, C., Trivella, M. and Bruster S. (2000) 'Demand for and supply of out of hours care from general practitioners in England and Scotland: observational study based on routinely collected data', *British Medical Journal*, 320 (7235), pp 618-621.

Saukko, P. (2008) 'Methodologies for Cultural Studies', in Denzin, N. K. and Lincoln, Y. S. (2008) *The landscape of qualitative research.* 3rd edn. Los Angeles: Sage Publications, pp 457-476.

Scrambler, A. and Scrambler, G. (1984) 'The illness iceberg and aspects of consulting behaviour', in Fitzpatrick, R. (1984) *The Experience of illness.* London: Tavistock.

Seale, C., Anderson, E. and Kinnersley P. (2005) 'Comparison of GP and nurse practitioner consultations: an observational study', *British Journal of General Practice*, 55 (521), pp 938-943.

Service Families Task Force (2010) *Service Families Task Force (SFTF) Relocation Aide Memoire – A Guide For Service Families on Moving.* London: Ministry of Defence.

Shaver, P. R. and Hazan, C. (1988) 'A Biased Overview of the Study of Love', *Journal of Social and Personal Relationships*, 5 (4), pp 473-501.

Shaw, C. (1999) 'A framework for the study of coping, illness behaviour and outcomes', *Journal of Advanced Nursing*, 29 (5), pp 1246-1255.

Shaw, C., Tansey, R., Jackson, C., Hyde, C. and Allan R. (2001) 'Barriers to help-seeking in people with urinary symptoms', *Family Practice*, 18 (1), pp 48-52.

Shipman, C., Dale, J., Payne, F. and Jessopp L. (1997a) 'GPs' views about out-of-hours working', *British Journal of General Practice*, 47 (425), pp 838-839.

Shipman, C., Longhurst, S., Hollenbach, F. and Dale J. (1997b) 'Using out-of-hours services: general practice or A&E?', *Family Practice*, 14 (6), pp 503-509.

Shipman, C. and Dale, J. (1999) 'Using and providing out-of-hours services: can patients and GPs agree?', *Health Social Care Community*, 7 (4), pp 266-275.

Shipman, C., Payne, F., Hooper, R. and Dale J. (2000) 'Patient satisfaction with out-of-hours services: how do GP co- operatives compare with deputising and practice-based arrangements', *Journal of Public Health Medicine*, 22 (2), pp 149-154.

Shipman, C., Payne, F., Dale J. and Jessopp, L. (2001) 'Patient-perceived benefits of and barriers to using out-of-hours primary care centres', *Family Practice*, 18 (2), pp 149-155.

Silverman, D. (2006) *Interpreting qualitative data methods for analyzing talk, text and interaction.* 3rd edn. London: Sage.

Silverman, D. (2010) *Doing qualitative research: a practical handbook.* 3rd edn. London: Sage Publications.

Simons, H. (2009) *Case study research in practice.* Los Angeles: Sage.

Simpson, R. G., Graham, D. and Martin, K. (2000) 'Analysis of out of hours telephone consultation at the Medical Reception Station Sennelager, British Forces Germany', *Journal of the Royal Army Medical Corps*, 146 (1), pp 28-30.

Somers, M. (1998) *Development and Preliminary Validation of a Measure of Belongingness.* PhD Thesis. Temple University, Pennsylvania.

Spencer, N. (2005) 'Does material disadvantage explain the increased risk of adverse health, educational, and behavioural outcomes among children in lone parent households in Britain? A cross sectional study', *Journal of Epidemiology and Community Health*, 59 (2), pp 152-157.

Stake, R. E. (1995) *The Art of Case Study Research.* London: Sage Publications.

Stake, R. E. (2000) 'Case Studies', in Denzin, N. K. and Lincoln, Y. S., (2000) *Handbook of qualitative research.* 2nd edn. London: Sage Publications, pp 435-455.

Stake, R. E. (2008) 'Qualitative case studies', in Denzin, N. K. and Lincoln, Y. S., (2008) *Strategies of Qualitative Inquiry.* 3rd edn. London: Sage Publications, pp 119-150.

Strachan, H., Armour, T., Healy, P. and Smith, M. (2010) *Report of the Task Force of the Military Covenant*. London: Ministry of Defence. Available at: http://www.mod.uk/NR/rdonlyres/3C6A501D-5A85-47C9-9D89-B99C5E428061/0/militarycovenanttaskforcerpt.pdf (Accessed 15 February 11).

Strauss, A. L. and Corbin, J. M. (1998) *Basics of qualitative research techniques and procedures for developing grounded theory*. Thousand Oaks: Sage Publications.

Strumpfer, D. J. (1970) 'Fear and affiliation during a disaster', *Journal of Social Psychology*, 82 (2), pp 263-268.

Stryker, S. (1980) *Symbolic interactionism: a social structural version*. Menlo Park, California: Benjamin Cummings Publishing Company.

Stryker, S. (2007) 'Identity theory and personality theory: mutual relevance', *Journal of Personality*, 75 (6), pp 1083-1102.

Surgeon General Department (2010) *Surgeon General's Department Research Compendium*. London: Ministry of Defence.

Ternus, M. P. T. (2010) 'Support for Adolescents Who Experience Parental Military Deployment'. *The Journal of Adolescent Health* 46 (3), pp 203-206.

The National Archives. (2010) *Data Protection Act 1998*. London: The National Archives.

Thompson, K., Parahoo, K. and Farrell, B. (2004) 'An evaluation of GP out-of-hours service : expectations of care', *Journal of Evaluation in Clinical Practice*, 10 (3), pp 467-474.

Thompson, M. J., Harnden A., and Mar C. D. (2009) 'Excluding serious illness in feverish children in primary care: restricted rule-out method for diagnosis', *British Medical Journal*, 338 (20 Apr), pp 1006-1008.

Trajanovska, M., Manias, E., Cranswick, N. and Johnston L. (2010) 'Parental management of childhood complaints: over-the-counter medicine use and advice-seeking behaviours', *Journal of Clinical Nursing*, 19 (13-14), pp 2065-2075.

Turnbull, J. C. (2008) *Out of Hours General Practice: an Investigation of Patients' Use and Experiences of Access to Services.* PhD thesis. University of Southampton.

Turnbull, J., Martin, D., Lattimer, V., Pope C. and Culliford D. (2008) 'Does distance matter? Geographical variation in GP out-of-hours service use: an observational study', *British Journal of General Practice*, 58 (552), pp 471-477.

Turnbull, J., Pope, C., Martin D. and Lattimer, V. (2010) 'Do telephones overcome geographical barriers to general practice out-of-hours services? Mixed-methods study of parents with young children', *Journal of Health Services Research Policy*, 15 (1), pp 21-27.

van Uden, C. J. T., Ament, A. J., Hobma, S. O., Zwietering P. J. and Crebolder H. F. (2005) 'Patient satisfaction with out-of-hours primary care in the Netherlands', *British Medical Council Health Services Research*, 5 (1), p 6.

Vedsted, P. Sorensen, H.T., Nielsen, J. N. and Olesenand, F. (2001a) 'The association between daytime attendance and out-of-hours frequent attendance among adult patients in general practice', *British Journal of General Practice*, 51 (463), pp 121-124.

Vedsted, P., Fink, P., Olesen, F. and Munk-Jorgensen P. (2001b) 'Psychological Distress as a Predictor of Frequent Attendance in Family Practice: A Cohort Study', *Psychosomatics*, 42 (5), pp 416-422.

Vincenti, G. (1990) 'Service families: a new perspective for the general practitioner', *British Journal of General Practice*, 40 (331), pp 78-80.

Vormbrock, J. K. (1993) 'Attachment theory as applied to wartime and job-related marital separation', *Psychological Bulletin*, 114 (1), pp 122-144.

Walsh, A., Edwards, H., and Fraser, J. (2008) 'Parents' childhood fever management: community survey and instrument development', *Journal of Advanced Nursing*, 63 (4), pp 376-388.

Weiss, R. S. (1991) 'The attachment bond in childhood and adulthood', in Parkes, C. M., Hinder, J. S. and Marris, P. (1991) *Attachment across the life cycle.* London: Routledge, pp 52-76.

Wensing, M. and Elwyn, G. (2003) 'Improving the quality of health care: Methods for incorporating patients' views in health care', *British Medical Journal*, 326 (7394), pp 877-879.

Westin, M. and Westerling, R. (2006) 'Health and healthcare utilization among single mothers and single fathers in Sweden', *Scandinavian Journal of Public Health*, 34 (2), pp 182-189.

Wikipedia. (2010). *Timeline of the British Army*, Available at: http://en.wikipedia.org/wiki/Timeline_of_the_British_Army (Accessed 8 February 11).

Wilson. C. (2005) *Improvised Explosive Devices in Iraq: Effects and Countermeasures.* Washington: Department of Defense. Available at: http://fpc.state.gov/documents/organization/57512.pdf (Accessed 25 March 11).

Wilson, S. (2008) *Family Wellbeing: Where we are and how we got there.* Masters of Strategic Studies Thesis. US Army War College, Washington.

World Health Organisation (2009) *The European Health Report 2009: Health and health systems.* Copenhagen: World Health Organisation.

Yin, R. K. (2009) *Case study research: design and methods.* 4th edn. London: Sage Publications.

Zakariassen, E., Blinkenberg, J., Hansen, E.H., Nieber, T., Thesen, J., Bondevik, G. T. and Hunskar, S.(2007) 'Locations, facilities and routines in Norwegian out-of-hours emergency primary health care services', *Tidsskrift for Den Norske Laegeforening,* 127 (10), pp 1339-1342.

Zola, I. K. (1973) 'Pathways to the doctor-from person to patient', *Social Science and Medicine*, 7 (9), pp 677-689.