Veteran adjustment to civilian life

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Paper 1: Literature Review

List of Abbreviations and Key Terms

BPS:	British Psychological Society
CASP:	Critical Appraisal Skills Programme
CBT:	Cognitive Behavioural Therapy
CCAT:	Crowe Critical Appraisal Tool
CTP:	Career Transition Partnership
DSM:	Diagnostic and Statistical Manual
EMDR:	Eye Movement Desensitization and Reprocessing
ITP:	Intensive Treatment Programme
MOD:	Ministry of Defence
NHS:	National Health Service
PTSD:	Post Traumatic Stress Disorder
Regular:	Full time military capacity
Reservist:	A member of a military reserve force. They are otherwise civilians, and in peacetime have careers outside the military.
SIT:	Social Identity Theory
SRA:	Service Resettlement Advisor
Theatre:	an area or place in which significant military events occur or are progressing
TA:	Thematic Analysis
UK:	United Kingdom
US:	United States
VA:	Veterans Administration

Thesis Abstract

The aim of this thesis is to explore the transition experiences of veterans when they leave the Armed Forces. Paper one consists of a literature review: a systematic search of relevant databases identified eight studies that are described and critically appraised. Thematic analysis produced four themes: 1) Mental health; 2) Length of Adjustment; 3) Barriers to transition and 4) Social Support. This review recommended that further research should explore qualitative methods with male and female British veterans. Paper two is a qualitative study exploring the experiences of medical discharge and the process of transitioning to civilian life in a sample of British veterans with PTSD. Purposive sampling was used to interview seven males receiving treatment at Combat Stress. Transcripts were analysed using Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) and four super-ordinate themes were identified: identity; disconnection; the will to live; and reaching out for help. Key findings are explored in relation to coping styles, shame and stigma, and Social Identity Theory (Tajfel & Turner, 1979). Future research should consider how to support this subgroup of veterans, and more qualitative methodology is needed to explore the individual transitional experiences. Paper three provides a personal reflective commentary of completing the research; the process of selecting a research topic; feelings of surrendering control; working with veterans; therapist versus researcher conflicts; and the researchers own connections with the military.

Paper 1: Literature Review

The transition experiences of veterans leaving the Armed Forces: A review of the literature

Paper 1 has been written with the intention of submission for publication to the ‘Journal of Aggression, Conflict and Peace Research (JACPR) and author guidelines for manuscript submission can be found in Appendix A.

The write up for this paper has used size 12 Arial font and has extended left hand margins, in accordance with the University requirements for thesis submission. Supplementary material has been included for the purpose of the final thesis write up in order to aid the reader; however these additional sections will be removed from the manuscript before submission for publication.

Abstract

Purpose: In the twelve months between November 2015 and November 2016, 15,140 personnel within the United Kingdom (UK) Armed forces left the service (National Statistics, 2016b). Since the Armed Forces Covenant was published in 2000, there has been increased focus on the way that service personnel transition from the Armed Forces into civilian life. To date, research has primarily focused on psychological treatments for veterans and PTSD symptomology. This review aims to provide an overview of the empirical literature that explores the transition experiences of veterans when they leave the Armed Forces.

Method: Relevant search terms were developed in order to systematically search using EBSCO Host and Web of Science. Eight studies met the inclusion criteria and were critically appraised and synthesised to provide a comprehensive literature review.

Results: Thematic analysis of the eight studies produced four themes: 1) Mental health; 2) Length of Adjustment; 3) Barriers to transition: internal (individual) factors and external (structural factors) and 4) Social Support.

Conclusions: Common methodological limitations were identified across the studies but despite this most findings suggest that a proportion of military veterans experience difficulties transitioning to civilian life. Although there are likely to be parallels and important themes that are shared across countries, there are also fundamental differences between the contexts and systems that cause difficulties for generalising findings. It is recommended that further research explores qualitative methods with samples of male and female British veterans.

Key words: military, ex-service, service leavers, adjustment, transition, Veteran

The transition experiences of veterans leaving the Armed Forces: A review of the literature

Literature overview

In the twelve months between November 2015 and November 2016, 15,140 personnel within the United Kingdom (UK) Armed forces left the service (National Statistics, 2016b). During this period the main reason for personnel leaving was through choice, i.e. the majority of service personnel voluntarily exited before the end of their agreed engagement or commission period. The Armed Forces Continuous Attitude Survey (National Statistics, 2016a) for this period indicated that 'satisfaction with service life' has fallen over time, and is 15 percentage points lower than a peak of 61% in 2009. A large proportion (59%) of personnel reported that they plan to stay in their service for as long as they can or until the end of their current engagement, and 25% stated that they intend to leave before the end of their current commission. Impact of service life on family and personal life, opportunities outside the service, a spouse's career, morale and pay were the main reasons for intentions to leave.

Resettlement support provided by the Armed Forces is graduated within three tiers and is dependent on length of service and reason for discharge (Ministry of Defence, 2016b). The first tier involves Resettlement Information Staff at the unit who can offer advice on entitlement and the administrative process to access it. The second involves support through a Service Resettlement Advisor (SRA). The final tier is provided by the Career Transition Partnership (CTP); a commercial partnership between Right Management and a number of voluntary sector charities funded through a Ministry of Defence contract. Different services are offered to leavers who are medically discharged and also to those who are administratively or dishonourably discharged.

In 2012 Lord Ashcroft was appointed the Prime Minister's Special Representative on Veterans' Transition and published 'The Veterans' Transition Review' shortly after (Ashcroft, 2014). It aimed to evaluate "the policies currently in place regarding Service Leavers' transition to civilian life,

the provision made by the state and others, and the practical experiences of those leaving the Forces" (p.29). The review highlighted 43 key recommendations, 40 of which the government agreed to implement (two were resolved by other means and the third involved Northern Ireland and remains unresolved). Lord Ashcroft's latest follow-up report suggests that there has been much "positive progress" (2016, p.4), attributed in part to the Armed Forces Covenant 2011. Despite this he suggested that changes have largely been seen within funding and policies and thus may not have been experienced by personnel themselves. The report highlighted the importance of early preparation for service leavers, with particular emphasis on housing and financial management. Some personnel reported difficulties translating their military experience and qualification into the civilian workforce. It suggested that aftercare for those with prosthetics had improved, as had GP's awareness of veterans' health. Lord Ashcroft highlighted a need for more mental health awareness for service leavers and their spouses and further training and resources for GPs. He also advocated less signposting between charities and welfare services to limit veterans from being passed from agency to agency.

As early as the Second World War there was acknowledgement of some of the challenges experienced transitioning from military to civilian life (Rogers, 1944). Rogers acknowledged that his preliminary findings suggested a correlation and not causation, and highlighted a number of "trends" (p.689): Vocational Readjustment, Hostilities, Disturbances of Self-Esteem, Uncertainty of Purpose, Combat Residuals, Marital and Family Adjustments and Adjustment to Handicaps. He also made a number of suggestions for Psychologists working with such individuals and referred to a "professional shortsightedness" that could impede therapy (p. 694). Despite Rogers' suggestions about the importance of further research in the area, two decades later a study cited only seven papers exploring retirement from the military (McNeil & Giffen, 1967). Kilpatrick and Kilpatrick (1979) later suggest that adjustment can be compared to a loss or grief reaction. They referred to a cyclic model in which veterans were reported to experience protest (categorised by feelings such as shock, confusion, denial, anger and

low self-esteem), through to despair (feelings of agony, grief, anguish and depression) and detachment (experienced as apathy, indifference, loss of interest and a desire to withdraw) before a final stage of recovery can be reached. The authors suggested that all veterans would experience the reaction-to-loss-process.

The Life After Service Studies (LASS) is a longitudinal Canadian research programme designed to aid understanding of the transition from military to civilian life and to ultimately improve the health of Veterans in Canada (Thompson et al., 2011). The latest published report suggests that although most adjusted well to civilian life, more than a quarter (27%) of Regular Force Veterans experienced difficulty (Van et al., 2013). When compared with age-sex matched Canadians, community belonging and satisfaction with life was lower for Regular Force Veterans, again consistent with earlier findings. The prevalence of heavy drinking was equal to the community comparisons.

In contrast to the aforementioned study, Iverson et al. (2005) found positive outcomes for service leavers. The sample consisted of the King's military cohort, a large random sample of British Armed Forces personnel that has been used in multiple studies (Ismail et al., 2002; Unwin et al., 1999). The results suggested that most veterans do well when they leave the Armed Forces and at the follow up stages 87.5% reported being within full time employment. The study proposed that psychological health is one indicator of whether a person is likely to stay in the military, and for those that do leave, whether they will be in full time employment as a civilian. The authors suggested that mental health symptoms remain relatively static after leaving the service and suggest therefore that those who leave with such difficulties are the most vulnerable to social exclusion or hardships such as unemployment. Despite these findings it is important to highlight that the response rate between the follow up stages ranged between 70.6-71.6% and the authors noted that the main reason for non-participation was owing to difficulties identifying a valid address for service leavers. As highlighted by Brunger, Serrato and Ogden; (2013), many of the transitional difficulties experienced by ex-service personnel, such as homelessness, are interlinked.

It is therefore likely that had this subset of participants been included in the study the proportion of veterans reporting adjustment difficulties would be significantly higher.

Verey and Smith (2012) completed semi-structured interviews with 15 British military personnel who had returned from active combat. The authors highlighted a lack of qualitative research into the difficulties adjusting to civilian life and suggested that prior studies had focused largely on quantifiable symptoms such as Post Traumatic Stress Disorder (PTSD). Using thematic analysis six major themes were detailed with the following key findings: the importance of being part of a group; personnel prefer to seek help from individuals with similar experiences; personnel prefer to seek help from friends as opposed to professionals; “macho” (p.230) approaches in the military may impede help-seeking and emotional disclosure; adjustments are necessary within personal relationships; and finally, participants experienced civilian society as lacking in real challenge and thus increased risk-taking behaviour.

Some research has focused on how military veterans’ transition to civilian careers (Clemens & Milsom, 2008; Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012). For example Drier (1995) identified five common stresses experienced by ex-service personnel during the job search phase of transition and adjustment: emotional; financial; ego; lack of confidence; and loss of identity. A study into employers’ perspectives found that although some organisations were open to employing veterans, others reported stereotypical views that ex-service personnel would lack skill sets and attitudes that could be relevant to their business (Forces in mind trust, 2015). High-ranking service-leavers were viewed by some as being “institutionalised” (p.22) although females in general were viewed more favourably. Further research is needed to understand the barriers to successful re-employment of veterans.

Other research has looked more broadly at the process of transition. Graves (2005) found that early retirement military officers experienced slightly lower measures of life satisfaction than comparison groups but more

specifically experienced lower levels of satisfaction with their financial situations. Søndergaard and colleagues (2016) carried out a systematic review that focused on the transition of the family post-service. They highlight a lack of research focused specifically on transition with most sources examining deployment and Service life more broadly. No studies from this review met the inclusion criteria for the current review.

Rationale for review

To date, research has primarily focused on psychological treatments for veterans with PTSD symptomology. Since the Armed Forces Covenant was enshrined in law there has been increased focus on the way that service personnel transition from the Armed Forces into civilian life. Taking this into account, a review of the literature pertaining to transition experience is now warranted.

There remains a lack of British research and as suggested above, the field is dominated by larger studies from the US and Canada. Due to the small amount of UK studies it was not possible to focus solely on these, and so worldwide studies have therefore been considered. The current review attempts to focus on how adjustment has been experienced from the perspective of veterans (i.e. not professionals working with them or family members). It will not include studies that focus on employment or education, or physical health and rehabilitation, as these factors have been explored in the literature.

Review question

How do veterans experience adjustment to civilian life when they leave the Armed Forces?

Aim

This review aims to provide an overview of the empirical literature that explores the transition experiences of veterans when they leave the Armed Forces. A systematic search of relevant databases identified selected studies that are described and critically appraised with a synthesis of the key

themes. Recommendations are provided to guide future research and clinical practice.

Methodology

Structure of the review

Chandler and Hopewell (2013) have described how evidence synthesis methods have developed rapidly in the last twenty years and contemporary systematic reviews incorporate a wider range of study designs (Schünemann et al., 2013), with more complex review questions (Petticrew & Roberts, 2006) and more recently, including qualitative research (Thomas et al., 2004). Nevertheless it is argued that the core principles still remain, the need for a clear review question, the need for transparency of methods, and the use of thorough search strategies to reduce the effects of publication bias (Petticrew, 2015). The current review was conducted in a systematic, explicit and reproducible manner (Booth, Papaioannou, & Sutton, 2012) and is summarised in figure 2 below.

Search Strategy

The Cochrane Library was searched on 26th October 2016 to determine whether there were pre-existing review articles. The search terms “military transition” OR “military adjustment” OR “post military” OR “veteran transition” OR “veteran adjustment” were used. This search did not identify any published systematic review papers. Further searches of the grey literature identified a systematic review by Søndergaard and colleagues (2016), however, their focus was on the transition of military families not individual personnel.

The search terms were developed following an initial scoping search on Google Scholar. To ensure that the search terms to be used were wide-ranging, the thesaurus function on EBSCOhost was used to search for similar relevant words. The American Psychological Associations’ Thesaurus of Psychological Index Terms (2007) was also referenced. Following discussion with a Senior Clinical Psychologist at Combat Stress and a Professor in Clinical and Forensic Psychology at Staffordshire University, the

search terms were finalised and are detailed below (figure 1). Due to a high number of irrelevant papers in the search results (n=11066) it was decided that some terms would be used to search by title only. The remaining terms were used to search within the title, abstract and key word fields.

Title (“transition” OR “readjust*” OR “adjust*” OR “reintergrat*”)

AND

Title, Abstract & Key word (“Ex-service” OR “military” OR “veteran” OR “civilian” NOT “deployment”)

Figure 1: Final search terms for the systematic search

Search Criteria

The following criteria were set to establish studies for inclusion in the review:

Inclusion criteria:

- Studies which included participants over the age of 18 years.
- Published in a peer-review journal.
- Participants are veterans (i.e. they have left the Armed Forces).
- Studies that capture the experiences of veterans themselves (as opposed to family members or professionals).

Exclusion criteria:

- Studies with a specific focus on employment or education.
- Studies that focus on the transition from deployments.
- Evaluations of treatment or interventions.
- Evaluations of descriptions of services for veterans.

Studies that included data on employment or education were considered for inclusion if this was not the main focus.

Search Strategy

The search terms were entered into the meta-search engine EBSCOhost on the 26th October 2016. Any papers after 1900 were considered. EBSCOhost was used to search the databases MEDLINE, PsycINFO, Ageline, CINAHL Plus, Academic Search Complete and PsycARTICLES. Limiters were applied (Peer reviewed journal articles; participants aged over 18) and duplicates removed: 232 results remained. The same search terms were entered into Web of Knowledge via the Web of Science Database Host. Due to differing search limiters it was not possible to search for participants over 18 without creating additional search terms: 2062 results remained. These were then screened using a three stage process in which papers were screened by title, abstract or full text.

To ensure that all key papers were included a manual search was carried out using Google Scholar and the reference lists of articles selected for full text screening were also inspected. A weekly alert was set up with EBSCOhost database to receive notification of new articles that met the search strategy. From October 2016 to March 2017 there were no new articles that were relevant. Additional scoping searches were not carried out using ProQuest or British Library EThOS Database as one of the key criteria for inclusion was publication within a peer reviewed journal.

All articles were assessed against the current review's inclusion and exclusion criteria prior to inclusion in the final selection.

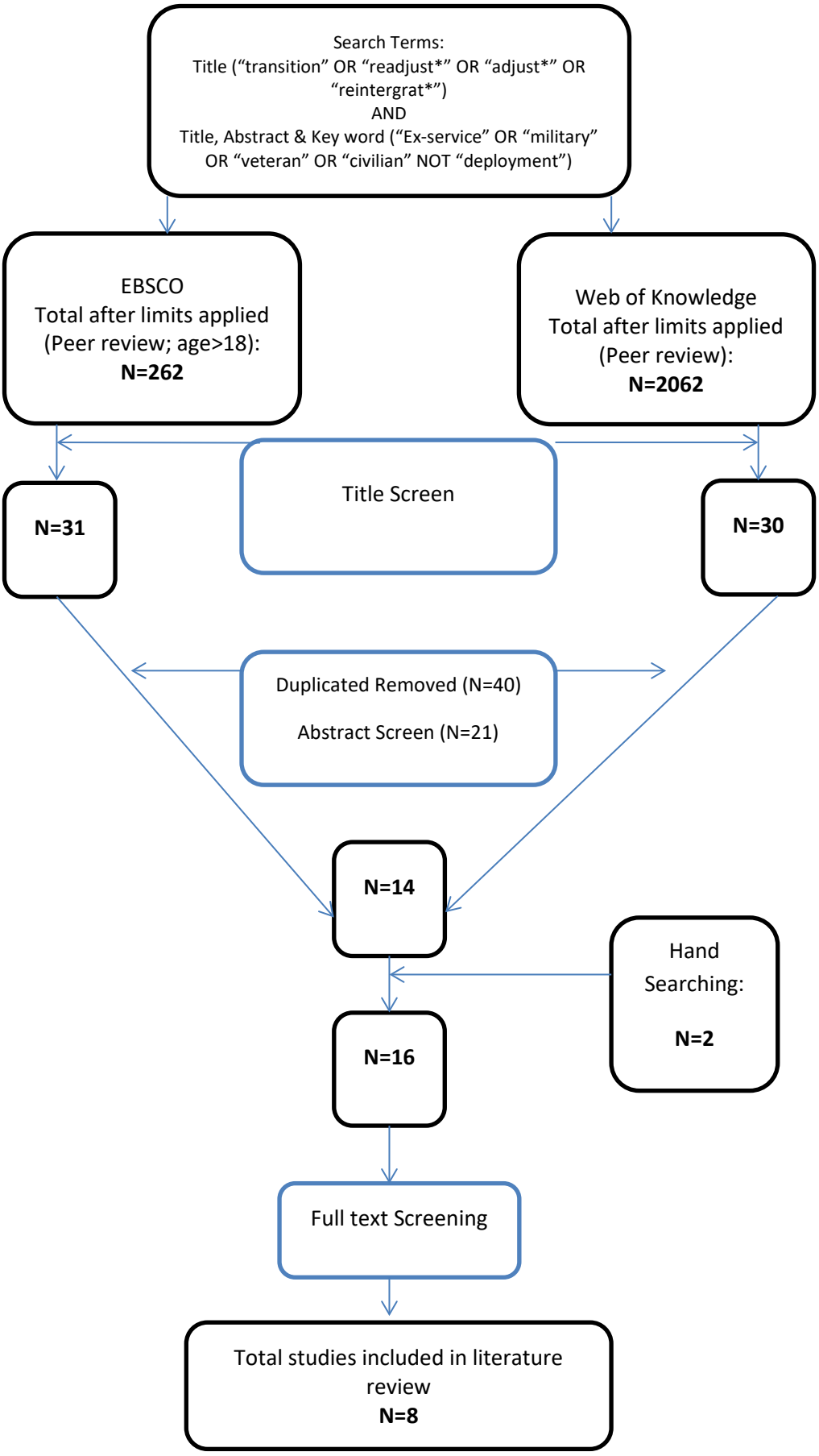

Figure 2: Flowchart demonstrating the literature screening process

Critical Appraisal

Booth, Papaioannou, & Sutton (2012) suggest that a quality assessment should be one that considers the validity, reliability and applicability of a study and its findings. Design-specific tools focus on methodological issues that are unique to the research design (Crombie, 1997) but this has been criticised due to the difficulty faced with comparing two different study designs (Sackett, 2000). In an attempt to overcome this limitation, generic critical appraisal tools have been developed to aid synthesis of evidence from a range of quantitative and qualitative study designs (Katrak et al., 2004). In the current paper the Critical Appraisal Skills Programme (CASP, 2013) was used for the qualitative studies and the Crowe Critical Appraisal Tool (CCAT, 2013) checklist was used for quantitative studies (Appendix B and C).

CCAT

The Crowe Critical Appraisal Tool (CCAT) (Crowe, 2013; Appendix B) was selected due to its good inter-rater reliability, with a Cronbach's alpha of 0.74, and construct validity (Crowe & Sheppard, 2011). The measure considers eight domains which are each given a score out of five. The total score is then calculated, with the highest possible score being 40. A higher score represents higher quality; the domain and total scores for the quantitative studies can be found in Table 2.

CASP

The CASP (Public Health Resource Unit, 2006; Appendix D) was used to critically appraise the qualitative papers. This measure was chosen to develop a consistent, structured approach to the evaluation of studies (Aveyard, 2010). The CASP consists of 10 questions that place emphasis on the rigour, credibility and relevance of the study (CASP, 2013). Each checklist item from the tool was entered into a table and was scored using a colour-coded system. Green indicated that criteria was met, and red that it was not. Orange was used to highlight where a criteria was partially met and pink when an item was not discussed (see table 1 below).

Summary of studies

The review is divided into qualitative and quantitative studies due to the differences in the criteria for the critical appraisal of quality. For further information a summary table can be found in appendix F.

Summary of Qualitative studies

The quantitative studies are appraised below (table 1) against the criteria listed within the CASP (Crowe, 2013).

Table 1: CASP scoring system

Factor No.	Criteria	Bruger, Serrato & Ogden (2013)	Ahern, Worthen, Master, Lippman, Ozer & Moos (2015
1	Clear statement of aims	Y	Y
2	Is qualitative appropriate	Y	Y
3	Is design appropriate for aims	Y	P
4	Is recruitment strategy suitable	P	Y
5	Date collection	Y	Y
6	Role of researcher	Y	NM
7	Ethical issues	P	Y
8	Rigour of data analysis	Y	P
9	Clear statement of findings	P	Y
10	Value of the research	Y	Y

Key	Degree criteria is met
Y	Yes
P	Partially
N	No
NM	Not mentioned

Both studies met the criteria partially or full with except to the domain 'role of researcher'. This domain included discussion on the influence of the researcher within the project, including for example, bias and subjectivity.

Brunger, Serrato and Ogden (2013) conducted interviews with 11 men who had previously served in the UK Armed Forces. The aim of the study was to explore the experiences of the transition from military to civilian life, and to identify some of the barriers and facilitators to re-employment. The authors included a detailed introduction to the topic in question, which was a key strength, and highlighted the lack of research in the area. The paper drew on Breakwell's (1986) Identity Process Theory (IPT) to consider "how one's identity might shift in response to contextual alterations" (Brunger, Serrato & Ogden, 2013, p. 88). The sample was recruited through a

supported housing project for ex-personnel but further details were not provided about the recruitment strategy, and inclusion and exclusion criteria were omitted. Interviews were semi-structured and were facilitated using open questions as “a means of guiding the interview rather than dictating it” (2013, p. 89). Data were analysed using Interpretative Phenomenological Analysis which gave rise to three master themes: characteristics of a military life, loss as experienced upon return to civilian life, and attempts to bridge the gap between the ‘two lives’. Transcending these themes was the notion of identity. A particular strength of the study were the authors’ reflections about the role of the researchers within the project. They highlighted that they were ‘outsiders’ in the sense that they were external to the military, and therefore unfamiliar with the military culture, which could have compromised the therapeutic alliance (Brunger, Serrato & Ogden, 2013). Although the analysis was thorough it was not clear whether measures were taken to improve the reliability and validity of the research, such as through triangulation with other researchers. Importantly the research explores a gap in the literature and although there is little discussion about avenues for future research, the authors do include detailed information on the implications for practice.

Ahern et al. (2015) facilitated interviews with military veterans but included a sample of both men and women. They clearly defined the objective of their study which was to explore the transition from military to civilian life in Afghanistan and Iraq Veterans using homecoming theory as a framework (Schuetz, 1945). They provided a detailed background to the research and highlighted the social and political context. The authors completed semi-structured interviews with participants (n=24) but it was not clear why this method was chosen compared to other qualitative designs. A key strength was the inclusion of the questions asked by researchers which would enable the study to be replicated with other samples. Interviews were audio-taped and transcribed before applying Thematic Analysis (TA). In line with TA (Braun, Clarke, & Terry, 2014) the analysis was primarily inductive and classified the data into emerging themes using coding. The study found three overarching themes and further subsidiary themes: military as family

(including caretaker and structure subthemes); normal as alien (including disconnection, unsupportive institutions, lack of civilian structure and loss of purpose subthemes) and searching for a new normal (including support from a navigator, embracing an ambassador role and ease with time subthemes). All themes were supported by data extracts. Although the researchers recruited from a wide array of veteran networks they were less likely to have included veterans who faced more difficulties in transition as they chose not to recruit from health care settings. It is widely accepted within qualitative research that by coding and analysing data the researcher uses his or her personal knowledge and experiences as tools to make sense of the material (McCracken, 1988). However the role and influence of the researcher were not explored and this was a key drawback of the study. In the discussion the authors do acknowledge other limitations and make several suggestions for how the findings can be used in clinical practice.

Summary of Quantitative studies

The quantitative studies are appraised below (table 2) against the criteria listed within the CASP (Crowe, 2013).

Table 2: Crowe Critical Appraisal Tool (Crowe, 2013)

Category	Thompson et al, 2013	Black & Papile, 2010	VanDen-Kerkhof et al, 2015	Wolfe et al, 1993	MacLean et al, 2014	Staden et al, 2007
1. Preamble /5	3	4	4	4	3	3
2. Introduction /5	3	5	4	4	4	3
3. Design /5	2	3	2	3	3	3
4. Sampling /5	4	1	3	2	3	3
5. Data collection /5	1	3	2	3	1	3
6. Ethical matters /5	1	0	2	1	0	2
7. Results /5	4	4	4	3	3	3
8. Discussion /5	5	4	4	3	4	4
9. Total /40	23	24	25	23	21	24
Combined Total %	57.5	60	62.5	57.5	52.5	60

Most studies scored highly on the quality of their introduction, particularly in relation to background literature and the research rationale. Most papers also scored high on the results and discussion sections. In contrast the papers scored lowest on the ‘ethical matters’ domain, with some studies failing to include any information around participant or researcher ethics. VanDenKerkhof et al. (2015) had the highest score of the six papers, and Maclean et al (2014) the lowest. The sampling and data collection domains produced the most variability in scores, ranging from 1 to 4 for the former, and 1 to 3 for the latter.

Wolfe, Keane, Kaloupel, Mora, and Wine (1993) completed research with Vietnam War veterans. They clearly identified their objective as identifying factors contributing to positive readjustment in theatre combat veterans of this war. A key strength of this study was that it was designed to address limitations in prior studies in terms of the sample and the instruments used to collect data. The study included questionnaire data from 152 community based male participants recruited from a range of public and private employment sectors. As well as collecting demographic data the authors used four psychometric measures, one of which (perception and attitudes of post war adjustment) had been evaluated for content validity on a pilot sample of eight combat veterans. Psychometric properties were not included for the remaining three measures and it was therefore difficult to assess their validity and reliability. Data were analysed by factor analysis, stepwise regression and ANOVAs and justification for each was given. The authors concluded two main findings: type of coping strategy predicted current adjustment better than combat exposure, and a subset of well-functioning veterans with substantial combat exposure was identified who employed non-avoidant coping styles. Although the paper stated that "assurances of research confidentiality" (1993, p. 191) were given it would benefit from a further statement concerning ethical approval and a declaration of any conflicts of interest. Another limitation was that the research did not assess the degree to which intervening life events influenced readjustment.

Maclean and colleagues (2014) carried out a questionnaire study with veterans and aimed to explore dimensions of post military adjustment to civilian life. They also sought to identify potential risk and protective factors associated with difficult adjustment. In contrast to Wolfe, Keane, Kaloupel, Mora, and Wine (1993) they provided comprehensive details in the sampling protocol including both inclusion and exclusion criteria. The authors also employed stratified random sampling which improved the generalisability of findings (Howitt & Cramer, 2005). This study would have been strengthened if the sample size was stated and associated calculations were included. The survey was conducted using computer assisted telephone interviews but it is

not clear who conducted these or what their involvement was in the study. A focus group is referred to but it is unclear what the purpose and outcome of this was. The detail of the data analyses was a particular strength including information about the handling of missing data. The study found the prevalence of difficult adjustment to civilian life was 25% (CI = 23.8%-26.9%, $p<0.05$). In multivariate regression, lower rank and medical, involuntary, mid-career, and Army release were associated with difficult adjustment, whereas gender, marital status, and number of deployments were not. The results were displayed clearly within a table to provide the reader with clarity. It is not clear if ethical matters were considered by the researcher and there was no statement about funding or potential conflicts of interest. The study relied upon self-reported data for many of the characteristics which could be prone to bias. The need for future research was discussed, in particular further qualitative studies to understand both the negative and positive experiences of transition.

VanDenKerkhof et al. (2015) aimed to explore the prevalence of chronic pain in Canadian Veterans and to identify potential correlates of chronic pain. They stated secondary objectives as: “to describe the prevalence of constant or reoccurring chronic pain/discomfort (chronic pain) and pain-related interference with activities (pain interference); and to identify sociodemographic, health behaviour, employment/income, disability, and physical and mental health factors associated with chronic pain and pain interference”. A questionnaire was used to collect data from 3154 veterans. Exclusion criteria were stated but inclusion criteria were omitted. Like Maclean et al. (2014) stratified random sampling was employed which improves the generalisability of the findings and is a strength of the research. The authors do not provide information about the psychometric properties of the questionnaire. The findings suggest that 41% of the population experienced constant chronic pain, 23% experienced intermittent chronic pain and 25% reported pain interference (effects of pain on daily living). Assistance with daily living tasks, back problems, arthritis, gastrointestinal conditions and being aged over thirty were independently associated with chronic pain. Assistance with tasks of daily living, back problems, arthritis,

mental health conditions, being aged over thirty, gastrointestinal conditions, low social support and non-commissioned member rank were associated with pain interference. Perhaps because this study was part of a wider research project, insufficient detail was provided about the background, design and methodology to enable replication, which compromises reliability (Howitt & Cramer, 2005). Nevertheless, the discussion section is a key strength and the results are critically compared to findings from a recent systematic review as well as providing guidance for future prospective studies.

Another Canadian transition study was published by Black and Papile (2010). The aims, clearly stated, were to better understand and conceptualise the transitional experiences of veterans and oriented the reader to the lack of research regarding former members of the Canadian Forces entering the civilian world. The study employed a questionnaire design that was distributed via purposive sampling but sample size was not stated. Attempts were made to pilot the measure but the sample chosen was small (n=3) and lacked diversity (all Caucasian males). The analysis consisted of descriptive statistics which were summarised in several tables. The authors conclude that 57.1% of the sample described their transition experience as difficult and 37.6% felt that they had not made a successful transition to civilian life. Another limitation was the overrepresentation of computer-literate respondents. A key strength of the research was independence from the Government. The researchers suggested that there is a “sometimes strained relationship” (2010, p.397) between veterans and the government and they highlighted that most literature comes from government conducted or government-sponsored studies.

Thompson et al (2013) stated their three aims clearly, which were to describe the Health Related Quality of Life (HRQoL) of veterans in relation to socio-demographics, health, disability and determinants of health; to identify protective and risk factors for HRQoL; and to compare HRQoL to Canadian normative data. A strength of this study was the sample, data were collected from a large number of veterans (n=3151) and like Thompson et al. (2013) and Maclean et al. (2014) stratified sampling was employed to improve the

generalisability of the findings. Both inclusion and exclusion criteria were clearly stated. The Short Form Health Survey (SF-12 V1) questionnaire was used and although the authors state that it has been widely used to collect HRQoL data, it is not clear how psychometrically sound the measure is. Demographic data was also collected from government databases to improve reliability. The study found that HRQoL varied across a range of biopsychosocial factors, suggesting possible protective factors, and vulnerable subgroups that may benefit from targeted interventions. The research had a good response rate and the sample was representative of regular Canadian Forces personnel who were released between 1998 and 2007, and were living in the general Canadian population. Like the study by VanDenKerkhof et al. (2015) the data summarised in this paper was from a wider research project and as a consequence it lacked detail about the background research and the data collection method. No information was given about ethical adherence or consideration.

Staden et al. (2007) focused on the factors associated with poor outcomes for personnel leaving the United Kingdom Armed Forces early via the United Kingdom Military Corrective Training Centre (MCTC). The background information was brief and the study would have benefited from a more thorough introduction to orient the reader to the topic in question. In contrast to the other papers included in this review, this research employed a longitudinal design to collect data from participants immediately prior to leaving prison and six months later which improves the validity of the findings. A key strength of the study was the inclusion of a comparison of the demographic variables for responders and non-responders at the follow-up stage. Overall, there were no statistically significant differences between the two groups, although there was a trend for responders to be less likely to have come from areas of social deprivation ($p = 0.063$) and more likely to have been diagnosed with a mental health problem before discharge ($p = 0.086$). The paper states that an interview was completed with participants at both stages although it is not clear why this method was chosen over a questionnaire design to collect quantitative data. Parametric (t test) and non-parametric (chi square) tests were used according to data type (continuous

and nominal) to investigate differences, and further univariate analysis was detailed. The results indicate that 56% of participants at the follow up stage were classed as being disadvantaged. Disadvantage at follow-up was associated with having a mental health problem at discharge, having no permanent accommodation to return to on discharge, shorter sentence lengths, and having to return to unit before discharge (administrative discharge). A limitation of the longitudinal design was the attrition rate, at the follow-up stage 32% of the original sample did not participate. The study findings were clearly linked to the initial aims and the authors placed them in the context of policy and the wider context.

Methodological Considerations

Despite the papers being methodologically sound, the following factors should be taken into account when drawing conclusions.

Three out of the eight studies sampled only male participants (Brunger, Serrato, & Ogden, 2013; Staden et al., 2007; Wolfe et al., 1993), one had 93.1% males (Black & Papile, 2010), two included 88% males (Maclean et al., 2014; VanDenKerkhof et al., 2015) and the remaining paper 71% males (Ahern et al., 2015). These gender biases may have implications when generalising the findings to growing numbers of female veterans.

Sample sizes ranged from 11-24 in the qualitative papers and 74-3154 in the quantitative papers. One study (Maclean et al., 2014) failed to include a sample size, and another (Black & Papile, 2010) did not include it until the discussion. Only one paper (VanDenKerkhof et al., 2015) provided details regarding their rationale for the sample size used and whether this was based on a power calculation or previous research and theory. The omission of these details could cause difficulties for generalising the findings.

Researchers have a duty to practise within the ethical guidelines of professional bodies such as the British Psychological Society (BPS, 2009) and the American Psychological Association (APA, 2016). Despite this, only four of the studies included a statement regarding ethical approval (Ahern et al., 2015; Brunger et al., 2013; Staden et al., 2007; VanDenKerkhof et al.,

2015). Three studies omitted details about funding (Black & Papile, 2010; Brunger et al., 2013; Maclean et al., 2014) and only three studies included a declaration about conflicts of interest (Ahern et al., 2015; Jim Thompson et al., 2013; VanDenKerkhof et al., 2015).

It is important to consider that all of the studies used self-report methods that may be prone to reporting bias. Only one study (Wolfe et al., 1993) included information on the psychometric properties of the measures employed. One study (Maclean et al., 2014) stated that they used a focus group to test their measure of adjustment to civilian life but no further information was provided. Another study (Black & Papile, 2010) piloted their measure but the sample chosen was small (n=3) and lacked diversity (all Caucasian males). In addition to self-report tools, three studies (Maclean et al., 2014; Staden et al., 2007; VanDenKerkhof et al., 2015) collected data from computerised and government databases, with consent, which increased the reliability of any conclusions drawn.

A final methodological factor to consider is the relationship between researchers and participants. The need for reflexivity is frequently referenced within the qualitative paradigm (Finlay, 2002) but the relationship between the participant and research is also thought to be important within quantitative research and features on most quality assessment tools such as the CCAT (Crowe, 2013). Only one study (Brunger et al., 2013) made reference to this and discussed, in particular, the researcher status and the implication of being an ‘outsider’ to the military culture. They concluded that the notion of “researcher acceptance” is of principle importance in undertaking meaningful research.

Despite the researchers’ attempts to explore an under researched area of psychological literature, there are methodological limitations in the papers which reduce the overall rigour and generalisability of the findings. This includes insufficient detail and consideration about ethical adherence, an over reliance on self-report data and a lack of researcher reflexivity.

Results

The data from the eight studies were analysed using Thematic Analysis (TA; Braun & Clarke, 2006).The analysis focused on the data published within the results and discussion sections and thus, the authors' interpretations. This method of analysis was chosen due to being theoretically flexible and allowing for construction of particular phenomena in ranging social contexts (Braun & Clarke, 2013). This was of particular importance in this paper due to the studies ranging in their countries of origin. In line with Braun and Clarke's guidance, the studies were read and re-read to improve familiarisation before developing codes and themes. The themes were reviewed, amended where necessary and named. Another strength of TA is to produce sophisticated, interpretative analyses that go beyond the obvious content (Braun & Clarke, 2013). Thematic Analysis of the eight studies produced four themes: Mental health; adjustment; barriers to transition; and social support (see table 3).

Table 3: Literature review themes

Themes	Subthemes	Papers in which the theme is present
Mental Health		Wolfe et al. (1993) Staden et al. (2007) Black & Papile (2010) Thompson et al. (2013) Brunger, Serrato & Ogden (2013) Maclean et al. (2014) VanDen Kerkhof et al.(2015) Ahern et al. (2015)
Adjustment		Wolfe et al. (1993) Staden et al. (2007) Black & Papile (2010) Brunger, Serrato & Ogden (2013)

		Maclean et al. (2014) Ahern et al. (2015)
Barriers to transition	Internal (individual) Factors	Wolfe et al. (1993) Staden et al. (2007) Black & Papile (2010) Brunger, Serrato & Ogden (2013) Ahern et al. (2015)
	External (structural) Factors	Staden et al. (2007) Black & Papile (2010) Thompson et al. (2013) Maclean et al. (2014)
Social support		Staden et al. (2007) Black & Papile (2010) Thompson et al. (2013) Brunger, Serrato & Ogden (2013) Maclean et al. (2014) Ahern et al. (2015)

Mental Health

The role of mental health was discussed in all papers: poor mental health was associated with a more problematic transition from military to civilian life. Some participants felt that their mental health problems were not appropriately diagnosed or addressed which exacerbated feelings of alienation (Ahern et al., 2015). Help-seeking was viewed as a weakness and a vulnerability within the military and this manifested as a barrier to a successful transition post discharge (Brunger et al., 2013). Mental ill health within this sample was also found to be higher than civilian populations (Staden et al., 2007). Alcohol, smoking and drug abuse were significantly related to difficult adjustments and this was also linked to poor mental health

(Black & Papile, 2010; Maclean et al., 2014; Staden et al., 2007; VanDenKerkhof et al., 2015). The use of substances may be understood as an avoidant coping strategy that was employed and shared during a veteran's time within the military. Avoidant coping is a strategy in which the person distracts their emotions, thoughts and behaviours away from an unpleasant experience (e.g., denying the existence of symptoms such as flashbacks; Litman, 2006). This type of coping strategy is paradoxical and has been found to enhance symptoms such as PTSD (Boden et al., 2014).

Adjustment

A period of adjustment accompanying the transition from military to civilian life was referenced in six of the papers. Of the six papers only one (Maclean et al., 2014) worked on the assumption that adjustment to civilian life was ongoing although all suggested that adjustment was multidimensional. Adjustment can be understood in terms of the "moving out" stage of Schlossberg's transition theory (1981) and is characterised by feelings of sadness and grief (Ackerman & DiRamio, 2009). Service members are required to adjust to a different kind of life without the familiarity of their colleagues around them who have had similar experiences and shared life events (Minnis & Wangs, 2011). Adjustment was thought to be a lengthy process and related to an identity shift (Brunger et al., 2013). Most people needed about a year to adjust although this period could be longer if there was ""psychopathology, substance use problems, or experiences of sexual assault in the military"(Ahern et al., 2015, p.8). Participants reported a similar number of difficulties in the early and later stages of their adjustment, with struggles with friendships and family being the most frequent (Black & Papile, 2010). It is important to consider, however, that there is no consensus of a definition of adjustment and it is likely to be a subjective concept that is specific to an individual. Comparisons and conclusions on adjustment should therefore be interpreted with caution.

Barriers to transition

The studies highlighted factors that negatively impacted on the transition period for veterans. Barriers to transition consisted of two subthemes: internal (individual) factors and external (structural) factors.

Internal (individual) factors. Participants reported viewing help seeking as a weakness and felt that mental health was stigmatised (Brunger et al., 2013). Pride inhibited service personnel from seeking support, possibly due to the high value placed on emotional strength in the military. Concerns about being judged by others for seeking help may be reflective of military culture that emphasizes self-reliance and hardiness. Veterans felt that civilian life lacked meaning and purpose and this is likely to have been exacerbated by external difficulties such as unemployment (Ahern et al., 2015; Staden et al., 2007). Coping style also impacted on the transition to civilian life. Veterans who endorsed externalisation, wishful thinking, and extreme avoidance, experienced poorer functioning and greater PTSD symptomatology (Wolfe et al., 1993).

External (structural) factors. This subtheme captured the difficulties that participants experienced in accessing mental health services and other organisations such as housing and employment agencies. Whilst in the Armed Forces, participants had structured access to in-service health care, often provided on site, and housing would also be arranged by a similar process in contrast to the civilian NHS system that they would encounter as a veteran, with different appointment availability, waiting times and location. On leaving the forces, veterans experienced difficulties obtaining employment (Black & Papile, 2010; Maclean et al., 2014; Staden et al., 2007) which contributed to lower health-related quality of life (Thompson et al., 2013). Military personnel are trained to “lose their sense of autonomous individuality” which may impede their ability to navigate healthcare and housing systems during the transition (Black & Papile, 2010).

Social support

Veterans highlighted the importance of social support and the difficulties faced when it was absent. They felt disconnected from people at home, including family and friends, who had not experienced military service (Ahern et al., 2015). The study also highlighted that veterans who were supported by a veteran peer or a veteran specific support system, providing both emotional and practical help, experienced a more successful transition. Difficult adjustment is associated with low perceived social support and a weak sense of community belonging (Maclean et al., 2014). This was supported by Thompson and colleagues (2013) who found greater physical and mental health in those with a strong sense of community belonging, and poorer health in those with low social support. These findings highlight the importance of social support and justify more research to explore how support affects transition and how relationships at home can be fostered and reconnected.

Discussion

Overview

This paper aimed to review the literature pertaining to transitional experiences of service personnel when they leave the Armed Forces. Key themes related to the process were found to be: mental health; length of adjustment; barriers to transition; and social support.

All of the eight papers that were reviewed, discussed the role of mental health and found that poor mental health was associated with a more problematic transition from military to civilian life. Some participants felt that their mental health problems were not appropriately diagnosed or handled (Ahern et al., 2015). Avoidant coping strategies such as drug and alcohol use were common and research suggests that they can have a detrimental effect on symptomology such as PTSD (Boden et al., 2014).

Most papers talked about a period of adjustment that accompanied the transition from military to civilian life. Of the six papers only one (Maclean et al., 2014) worked on the assumption that adjustment to civilian life was

ongoing, although all suggested that adjustment was multidimensional. There appears to be considerable debate about the time scale and components of adjustment. It is important to note that there is no consensus of a definition of adjustment and it is likely to be a subjective concept that is specific to an individual. Comparisons and conclusions on adjustment should therefore be interpreted with caution.

Most of the papers referred to barriers to transition with some participants reporting feeling that help seeking was a weakness and felt that mental health was stigmatised (Britt et al., 2008). These cognitions may be reflective of military culture that emphasises self-reliance and hardiness (Vogt, 2011). Other studies reported difficulties in accessing mental health services and other organisations such as housing, in contrast to the accessible systems within their previous military institution.

Social support was perceived as having an important role in adjustment and veterans reported difficulties. Many veterans report experiences of isolation and loneliness (Arthur & Pedersen, 2008) and a disconnection between veterans and the people at home, including family and friends, who had not experienced military service (Ahern et al., 2015). Veterans who were supported by a veteran peer or a veteran specific support system, providing both emotional and practical help, experienced a more successful transition (Ahern et al., 2015).

Clinical Implications

In 2015 an estimated 2.56 million UK Armed Forces veterans resided in households across Great Britain (Ministry of Defence, 2016a). Key principles of the Armed Forces Covenant have recently been enshrined in law within the Armed Forces Act 2011. This legislation recognises that the government and the nation have an obligation to the Armed Forces community and outlines how veterans should expect to be treated. Lord Ashcroft (2014) has argued that “society has a duty to ensure that on leaving the military they are integrated successfully back into civilian society and suffer no disadvantage as a result of having served” (p. 7).

The mental health of service-leavers is frequently reported in the media and is often the focal point for intervention. In England, support for veterans is written into the NHS England constitution (NHS England, 2016) and has consequently received increased attention. Ashcroft (2016) reported that NHS England is soon to publish details on a Transition Intervention Liaison programme that aims to improve the handover of a military service leaver with mental health difficulties. It is hoped that this programme will decrease some of the structural barriers to accessing support. Despite this, the stigma of mental health and help-seeking are likely to prevail. It is important for these factors to be explored within resettlement services, as well as the more practical focus on housing and employment.

More globally it will be important for any professionals working with veterans to have knowledge of the transition process and factors that can aid or impede adjustment. This may also go some way to shifting the negative attitudes towards help-seeking (Britt et al., 2008). Ahern and colleagues (2015) discuss the theme of 'disconnection' with those at home that have not shared the experience of military service. Given the nature of the transition process it will also be important to involve spouses and wider family, where appropriate. Interventions to connect service leavers to specific veteran peer support systems have been found to be successful, but are only available in some countries. In the current review the resource of a veteran peer helped support service-leavers to a successful transition review by offering both practical and emotional support (Ahern et al., 2015). Other studies have supported this finding (Barber, Rosenheck, Armstrong, & Resnick, 2008; Pfeiffer et al., 2012; Viverito, Cardin, Johnson, & Owen, 2013) although the research to date is limited.

Review limitations

Only eight studies met the inclusion criteria for this review as there is limited research on veteran adjustment that does not focus on PTSD or employment. The review was conducted by a single researcher and subjectivity may have influenced the short-listing of papers and development of themes. The researcher has attempted to compensate for this by

completing a comprehensive search of the existing literature and presenting a detailed account with as much transparency as possible.

Another key limitation of the review concerns the generalisability of the findings. Although there are likely to be parallels and important themes that are shared across countries, there are also fundamental differences between contexts, systems and military experiences. For example, in contrast to the UK, specialist services such as the Veterans Administration (VA) support system are offered throughout the US. The review has highlighted a discrepancy between the number of UK and international sources, with US and Canadian papers dominating the field, and thus further research with UK service leavers is needed.

Future research

Whilst much has been written about veterans in the US and Canada, very little research has focused on the experience of their British colleagues (Iversen et al., 2005). The challenges facing UK military service leavers are inadequately reflected in the literature and require further attention in order to better develop support and develop services that best meet their needs (Sondergaard et al., 2016). Of the UK studies included in this review one focused on those leaving the forces via Military Corrective Training Centres (Staden et al., 2007) and one focused on the role of identity (Brunger et al., 2013). Whilst these provide valuable insights there is a need for further research to focus on wider aspects of the transition from military to civilian life.

Verey and Smith (2012) suggest that more research is needed in order to discriminate between those who are in current transition and those who no longer serve in the Armed Forces, due to differing supportive social networks and professional mechanisms. Of the studies presented in this review, only two employed a qualitative approach. Qualitative research provides emphasis to the meanings, experiences and views of individuals (Al-Busaidi, 2008). It focuses on lived experiences and would go some way in providing the rich data that is currently lacking. Maclean and colleagues (2014) support this view and emphasise that qualitative studies are needed

to understand both the positive and negative experiences of this unique transition.

There was a marked lack of female participants within the studies reviewed. In the five papers that included females, they made up a much smaller proportion of the sample than their male counterparts although this may be reflective of the gender split within the Armed Forces. Nevertheless there may be crucial differences faced by women who have left the Armed Forces and research that actively strives to recruit female participants will be integral to further understanding the factors that contribute to the process of adjustment.

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Paper 2: Research Paper

From civilian to military life, and back again: The experiences of veterans with PTSD leaving the British Armed Forces via medical discharge

Paper 2 has been written with the intention of submission for publication to the 'Journal of Aggression, Conflict and Peace Research (JACPR) and author guidelines for manuscript submission can be found in Appendix G.

The write up for this paper has used size 12 Arial font and has extended left hand margins; in accordance with the University requirements for thesis submission. All text is 1.5 line spaced. For the purpose of this thesis submission additional material has been included, which will be removed before manuscript submission.

Disclaimer: This research was sponsored by Staffordshire University and conducted within Combat Stress. The findings and discussions of this research are that of the author and may not reflect the views of either institution.

Abstract

Purpose: Compared to research on the prevalence of PTSD in military veterans, relatively little is known about adjustment experiences of veterans post service, and even less about those who leave via medical discharge. Studies exploring the transition to civilian life have mostly used samples from Canada and the US (Maclean et al., 2014; Thompson et al., 2013). The present study aimed to explore the experiences of medical discharge and the process of transition to civilian life with a sample of British veterans who have a diagnosis of PTSD.

Method: Semi-structured interviews were conducted with seven Army veterans with PTSD. Participants were recruited via Combat Stress and transcripts were analysed using Interpretative Phenomenological Analysis (IPA).

Results: Four super-ordinate themes were identified: Identity; Disconnection; The will to live; and Reaching out for help. All participants described difficulties in their adjustment to civilian life.

Conclusions: Key findings are explored in relation to coping styles, shame and stigma, and Social Identity Theory (Tajfel & Turner, 1979). It is recommended that further research uses qualitative methods with samples of both male and female British veterans.

Key words: Military, Ex-Service, Service Leavers, Adjustment, Transition, Veteran, PTSD

From civilian to military life, and back again: The experiences of veterans with PTSD leaving the British Armed Forces via medical discharge

The history of military psychology

Research into the mental health of military personnel is thought to have started during the First World War (1914-1918) when the term ‘shell shock’ was first coined (Mott, 1919). Siegfried Sassoon was one of the first writers to use poetry to describe the realities of war, and he himself later spent time at a hospital for soldiers thought to be suffering from these difficulties. Shell shock was primarily conceived as a neurological lesion and thought to be the result of powerful compressive forces sustained during battle (Mott, 1916, 1917). However despite this, an increasing number of soldiers without head injuries began to present with similar symptoms and a controversial debate ensued. Charles Myers, Consultant Psychologist to the British Army, suggested a psychological explanation for the first-hand experiences that he witnessed and emphasised the emotional impact of the experiences (Myers, 1916). It is thought that this theory received increased support as it offered the British Army an opportunity to return these shell-shocked soldiers to frontline duties, particularly relevant at a time when there was an increasing shortage of active-duty troops (Jones, Nicola, Fear, & Wessely, 2007). In 1980 the American Psychiatric Association first recognised these difficulties as Post Traumatic Stress Disorder (PTSD) in its third edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980). More recently the fifth edition positions PTSD in a new chapter on Trauma- and Stressor-Related Disorders, a change from the previous addition in which it was addressed as an anxiety disorder (American Psychiatric Association, 2013).

During the last century, and in particular as a result of World War I (1914-1918) and II (1939-1945), the Vietnam War (1955-1975), the Gulf War (1990-1991) and later conflicts in Iraq (2003-2011) and Afghanistan (2001-2014), there has been increased focus on the evaluation and treatment of post-combat injuries (Iversen, 2003). Many service personnel have been

physically injured in wars such as these but due to advances in protective armour and medical technology, a large proportion have survived life threatening injuries. Previous research has indicated a strong relationship between physical and psychological injuries during wartime (Iversen, 2003; Jones & Wessley, 2001; Sandweiss et al., 2011). As well as an increased number of survivors of war there have also been changes in legislation that dictate the care that veterans should receive (e.g. Armed Forces Act 2011).

Post Traumatic Stress Disorder

Various studies have attempted to provide an estimate of the prevalence of PTSD among military personnel. Fear et al (2010) conducted a study with members of the UK armed forces that had deployed to Iraq and Afghanistan. The large study sample (n=9990) found the prevalence of probable post-traumatic stress disorder to be 4.0%, compared with 19.7% experiencing symptoms of common mental disorders. Deployment to Iraq or Afghanistan was significantly associated with alcohol misuse for regulars and with probable post-traumatic stress disorder for reservists.

In other studies the prevalence rate has been estimated to be much higher. A recent meta-analysis of military personnel from the United States, Canada, and the United Kingdom found that 12.9% of Iraq veterans had PTSD, compared to 7.1% of Afghanistan veterans (Hines, Sundin, Rona, Wessely, & Fear, 2014). The same meta-analysis found that combat veterans experience higher rates of PTSD (12.4%) when compared with their colleagues in peace keeping roles (4.9%). Ginzburg and colleagues completed a 20-year longitudinal study of 664 veterans of the 1982 Lebanon war (Ginzburg, Ein-Dor, & Solomon, 2010). Veterans were assessed at three time periods; 1 year post war, 2 years post war and twenty years post war. Rates of PTSD only ranged from 9.3% to 11.1%, PTSD and depression from 1.2% to 4.5%, PTSD and anxiety from 9.3% to 12.1%, and for triple comorbidity from 26.7% to 30.1%.

Fewer studies have explored the adjustment to trauma. Sommer and Ehlert (2008) explored adjustment in a sample of trauma exposed refugees and found that level of education played a significant role in the development

of PTSD symptomatology. A longitudinal study with Emergency Services personnel found similar findings (Marmar et al, 1999). The authors concluded that workers who had experienced more catastrophic exposure and those prone to dissociate at the time of the critical incident were at a greater risk of for chronic symptomatic distress.

Leaving the Armed Forces

Between November 2015 and November 2016, 15,140 personnel within the United Kingdom (UK) Armed forces left the service (National Statistics, 2016b). During this period the main reason for personnel leaving was through choice, i.e. the majority of service personnel voluntarily exited before the end of their agreed engagement or commission period. The Armed Forces Continuous Attitude Survey (National Statistics, 2016a) for this period indicated that ‘satisfaction with service life’ has fallen over time and 25% of those surveyed intend to leave before the end of their current commission. Impact of service life on family and personal life, opportunities outside the service, a spouse’s career, morale and pay were the main reasons for intentions to leave.

Most of the studies investigating how veterans experience the adjustment process have used Canadian and USA samples. Maclean et al. (2013) carried out a multivariate logistic regression analysis on data collected from a national sample of 3,154 veterans released from the regular Canadian Forces during a 9 year period. They found that 25% of the sample reported a difficult adjustment to civilian life, and that lower rank, medical, involuntary, mid-career, and Army release were associated with difficult adjustment. Black and Papile (2010) found that 37.6% of Canadian ex-forces personnel (n=173) felt that they had not made a successful transition to civilian life. Other studies have attempted to report the differing subjective experiences by conducting interviews with veterans, one of which was conducted with ex-servicemen who had previously served in the UK armed forces (Brunger, Serrato, & Ogden, 2013). The authors reported that participants (n=11) described their experiences in terms of three broad themes: characteristics of a military life; loss as experienced upon return to civilian life; and the

attempt to bridge the gap between these two lives. They highlighted the importance of identity, illustrating that the transition from military to civilian life can be viewed as a shift in sense of self from soldier to civilian. A study (Ahern et al., 2015) with 24 US Afghanistan and Iraq veterans found similar themes. Using thematic analysis the authors developed three overarching themes: Military as family (how the military environment formed a 'family' that provided support and structure); Normal as alien (disconnection from people at home, lack of support from institutions, lack of structure and loss of purpose); and Searching for a new normal (strategies and supports found to reconnect in the face of these challenges). It is widely thought that adjustment is multidimensional and there appears to be considerable debate about the time scale and components of adjustment. It is important to note that there is no consensus on a definition of adjustment and it is likely to be a subjective concept that is specific to an individual.

Medical Discharge

Less is known about the experiences of veterans who have been medically discharged from the military. A review conducted in 2017 (Lovatt et al.) indicated that no existing studies have focused on the transition of this client group back into civilian life. In a study on the potential risks and protective factors during post military adjustment, Maclean and colleagues found that medical release was associated with a difficult adjustment period (Maclean et al., 2014). Other research has found medically discharged personnel to have a greater risk of suicide (Statistics Canada, 2011) and less perceived financial security (Marshall, Matteo, Pedlar, & Marshall, 2005).

Whilst much has been written about veterans of the US and Canadian armed forces, very little is known about the experiences of British veterans. Although there are likely to be parallels and important themes shared across countries, there are also fundamental differences between the contexts, systems, supports and the military experiences. Health care systems and resettlement packages differ significantly between countries and it is therefore problematic to generalise the findings of non UK studies to the experiences of British Veterans.

Most research has employed questionnaire designs and previous research has highlighted the importance of qualitative studies to better understand both the positive and negative experiences of transition (Maclean et al., 2014).

Research Aims

The present study aims to explore, through Interpretative Phenomenological Analysis (IPA), the experiences of medical discharge and the process of transitioning to civilian life in a sample of British veterans with PTSD.

Research Question

How do veterans with PTSD experience medical discharge and transition into civilian life?

Methodology

Research Design

To facilitate an exploratory focus in line with the research aims, a qualitative research design was chosen. Interpretative Phenomenological Analysis (IPA) was considered appropriate for this study due to its phenomenological underpinnings; it is focused on exploring experience in its own terms (Smith, 2003). As well as its emphasis on personal meaning and sense-making in a particular context, IPA is an established methodology for exploring life transitions and identity (Smith, Flowers, & Larkin, 2009).

Participants

In line with IPA methodology, the British Psychological Society propose “fewer participants examined at a greater depth is always preferable to a broader, shallow and simply descriptive analysis of many individuals” (BPS, 2011, p. 756). Purposive sampling was employed to recruit a sample of seven participants, as recommended for an IPA doctoral study (Smith et al., 2009). Participants were recruited between May 2016 and December 2016. Inclusion and exclusion criteria are outlined in Table 1. To be classified

as a veteran participants should have served for a minimum of 1 day, a criteria employed by both military and treatment services.

Table 1: Inclusion and exclusion criteria

Inclusion Criteria	**Exclusion Criteria**
Diagnosis of PTSD*	Serving personnel
Medical discharge from the armed forces	
Veteran status**	

*Diagnosis made during Combat Stress assessment

**Participants should have a minimum of 1 day serving in the armed services

All participants were male and former Army personnel. The mean age was 40 (range: 22-55 years) and all participants identified as being “White British”. All had experience of working within a combat role and the average length of service was 13 years (range: 4-24.5). All reported at least one physical injury or health condition as a direct result of their service. Further demographic information is presented in Table 2. Pseudonyms were assigned to participants to protect their anonymity.

Table 2: Participant demographics and military characteristics

	1	2	3	4	5	6	7
Pseudonym	Tom	Andy	Dale	James	Charlie	Billy	Eric
Age	39	42	22	55	49	31	45
Education level	CSE/GCSE's	CSE/GCSE's	No formal qualifications	CSE/GCSE's	CSE/GCSE's	Degree	CSE/GCSE's
Accommodation	Own home	Own home	Living with family	Own home	Private renting	Own home	Own home
Employment status	Full time paid role	Sick leave from full time paid role	Not working – seeking employment	Not working due to ill health	Not working due to ill health	Voluntary role. Not working in paid employment due to ill health.	Not working – seeking employment
Relationship status	Married	Married	In a relationship	Married	Single	Married	Married
Enlistment status	Regular	Regular and Reservist	Regular	Regular	Regular	Regular	Regular and Reservist
Role during service	Combat	Combat	Combat	Combat	Combat	Combat and Combat Support	Combat
Length of service (years)	16	21	5	4	24.5	3.5	17
Rank at discharge	Sergeant	Corporal	Private	Private	Acting Sergeant	Private	Corporal
Physical injury from service	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Ethics

The research was designed and conducted in line with the British Psychological Society's ethical guidelines (2009). Ethical approval was gained from Staffordshire University Ethics Committee Board (Appendix H) and Combat Stress Ethics Panel (Appendix I). Informed consent was obtained from all participants.

Materials

In line with IPA methodology, a semi-structured interview was utilised (Smith et al., 2009) to obtain meaningful knowledge (Mason, 2002). The interview schedule was presented visually to allow the researcher to maintain a flexible and creative approach that was participant led (Appendix J). The interview schedule was revised following feedback from members of the research team and discussion at a specialist IPA group.

Recruitment and Procedure

Recruitment was carried out at Combat Stress, a UK military charity specialising in the care of veterans' mental health. All veterans receive a comprehensive psychiatric and psychological assessment by members of the multi-disciplinary team prior to engaging in treatment. Veterans enrolled on the Intensive Treatment Programme (ITP) were informed about this research and those that met the inclusion criteria were invited to participate. Information and informed consent sheets were also given at this point. Combat Stress informed the researcher when an individual had consented to participate and a date was arranged for a face-to-face interview. Due to the nature of their difficulties and the associated distress, veterans were interviewed in the sixth and final week of their residential treatment stay, at a time when their mental health was expected to be more stable. Participants' individual support workers were also consulted to discuss the suitability of their participation. Following their interview, each participant had access to around the clock support from the team at Combat Stress.

Prior to their interview, each participant was asked to re-examine the information sheet and any questions were explored. Written informed

consent was obtained and information given about how to withdraw data from the study (appendices K and L). Demographic information and relevant military variables were obtained at the start of the interview. All interviews were audio recorded and ranged between 29 and 65 minutes (mean duration 48 minutes). On completion of the interview, participants were given a verbal debriefing and reminded of the support services documented within the information sheet.

Analysis

Data analysis followed the iterative and inductive cycle outlined by Smith et al. (2009). Following each interview initial notes were recorded as a means of reflecting upon the researchers impressions of the interaction and salient points. The recordings were re-played a number of times and then transcribed verbatim by the researcher to provide a semantic record of the interview. To further immerse in the data, the researcher re-read the transcript and noted additional observations about the interview and comments of potential significance. The second stage of analysis involved line by line coding using different coloured inks for descriptive, linguistic and conceptual comments (Appendix M). Analysing these exploratory themes led to the development of emergent themes which were then typed into a chronological list (Appendix N). The emergent themes were printed on to strips and eventually clustered to search for connections using abstraction, polarisation, contextualisation, numeration and function (Smith et al., 2009, Appendix, O).This was repeated for each case and they were entered into a master table of themes (Appendix Q). For cross comparison between cases, each participant's emergent themes were added to coloured paper to enable the researcher to develop a visual map of emerging themes (Appendix P). This led to the development of revised super-ordinate and sub-themes.

Reliability and Validity

Initial coding and subsequent themes were reviewed by members of the research team which included a Professor of Clinical Psychology experienced in research, and a Clinical Psychologist working with military personnel. They were also reviewed by a Clinical Psychologist with a special

interest in IPA and discussed within a monthly IPA group. Inconsistencies were explored and themes were amended as necessary.

Personal and epistemological reflexivity

Reflexivity necessitates an awareness of the researcher's influence on the construction of meanings and an acknowledgement of the impossibility of remaining 'outside of' one's subject matter while conducting research (Willig, 2008). It involves exploring "the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research" (Nightingale & Cromby, 1999, p.228).

Personal reflexivity is the process of reflecting upon the ways in which our own values and beliefs, as well as social identities, have shaped the research (Willig, 2008). Bracketing is employed to put aside one's own beliefs about the phenomenon under investigation or what one already knows about the subject (Carpenter, 2007).The researcher is a 28 year old, white British female, working as a Trainee Clinical Psychologist within an NHS setting. The researcher has an interest in trauma and has previously worked within a trauma and self-injury programme. The researchers' experience with the Armed Forces is a result of personal connections with the military: her partner is a serving member of the Royal Air Force. The researcher also wanted to share the voices of the "heroes" that she felt often become muted and forgotten. Preconceptions identified in the bracketing process included an assumption that veterans are treated well by the military post service, and that the difficulties experienced by veterans with PTSD more often than not led to marital breakdown. Credibility and validity checks were carried out throughout the research process in supervision and in an IPA group to ensure these preconceptions and biases were not imposed on the findings. Awareness of researcher biases was also facilitated by maintaining a research diary.

Epistemological reflexivity involves reflecting upon the assumptions that have been made by the researcher in the course of the research, and the implications of such assumptions for the findings (Willig, 2008). IPA is an inductive, idiographic approach which aims to provide detailed examinations

of personal lived experience (Smith & Osborn, 2015). This understanding of subjective sense-making is congruent with the researcher's critical realist epistemological position. Critical realism has emerged out of the positivist and constructivist paradigms of the 1980s (Denzin & Lincoln, 2005) and uses components of both approaches to provide a detailed account of ontology and epistemology (Brown, Fleetwood, & Roberts, 2002). A critical realist approach does not assume that data constitutes a direct reflection of what is going on in the world, but that interpretation is required to further our understanding of the underlying structures and phenomena (Bhaskar, 2011; Willig, 2008). This study therefore aimed not to identify a singular truth or knowledge, but to provide a comprehensive and rich interpretation of veteran's subjective experiences.

Results

The results revealed four super-ordinate themes and 12 sub themes (Table 3) which were all present in over half of the participants' interviews. An additional analysis table contains further extracts across the sample to illustrate supplementary evidence for the themes (Appendix R). Identity pervades the entire analysis, but is presented first to provide the reader with a context to understand the military culture. The remaining super-ordinate themes attempt to capture an essence of the way in which participants employed coping mechanisms, how they experienced changes in their relationship with the self and others, and finally their adjustment to their position within the wider system.

Table 3: Super-ordinate Themes and Sub-ordinate Themes

Super-ordinate Theme	Sub-ordinate Theme	Theme present in case(s)
Identity	Becoming part of the outgroup: “being a second class citizen”	All
	The old self versus the new self	1,2,3,4,6
	Putting on a front	All
Disconnection	Disconnection from self	All
	Disconnection from others	All
The will to live	Buffering the self	1,2,4,5,6
	Coping the only way we know how	All
	Meaning making	1,2,3,4,6,7
	Humour as a shield	1,3,4,6
Reaching out for help – journey to help	Rejection by the military: There’s the door, cya later!	All
	“Pushed from pillar to post”: Experiences of help seeking post military	2,3,4,5,6,7
	“It’s about education”: Future service provisions	All

Identity

Throughout their interviews all participants described challenges to their identity following medical discharge.

Becoming part of the outgroup: "being a second class citizen". Military identity can be understood in terms of social identity theory (Tajfel & Turner, 1979). This framework proposes that people categorise others as belonging to different groupings and then adopt the identity of the group they consider themselves as belonging to. It also states that the in-group (the group we belong to) will discriminate against the out-group (the group we don't belong to) in order to enhance self-image. Upon leaving the military, some participants attempted to distance themselves from their previous identity or grouping. This may be seen as participants rejecting their previous 'in-group' in favour of their new grouping.

> *"You see when you leave you are given 6 months mental health support from the army, so it's like provided by them. It was on the army barracks and I didn't wanna associate with it. I thought like I'm out now, I don't want anything to do with you.*" *Dale, L107-112*

Some participants talked about the challenges of adopting their new civilian identity and reported feeling "different" from other people (Dale, L210). This may have resulted in participants withdrawing further away from civilians and thus having fewer opportunities for positive experiences, and as a consequence reinforcing the differences. In line with Social Identity Theory some participants described military personnel as superior to civilians, so the loss of a military identity appears to lead to a loss in self-esteem.

> *"Oh yeah, that's the only way you could feel. You are now a second class citizen. I was A1 before and now I'm not anymore, I'm not good enough anymore. " James, L215-221*

Some participants stayed loyal to their military identity and instead presented a negative view of the civilian out-group:

> *"Well the way they work. In the army we get the job done where as they are a bit slap dash. I think it's the way you've been trained.*

> *You've been trained in controlled aggression whereas civilians are not and they get upset. They have no format. Civilians, you talk to them and you have to be one step ahead of them, they're different." Andy, L120-124*

The old self versus the new self. As well as categorising people, a common process was the splitting of the self into "old self" and "new self". This may be seen as a way of making sense of the changes in identity and the consequences of their behaviour:

> *"I think what's happened is I was a lot more tolerant with people and people being dicks and stuff. People seem to think they can run all over you…but in the last year it's like if someone told me to do something and I knew it wasn't going to work then I would just say, I lost all tolerance with people. Including in my marriage and voluntary work." Billy 450-461*

The categorisation appeared to have a protective function for some, with participants presenting the new self as superior to the old self which emphasised their commitment in the journey to recovery:

> *"Oh yeah definitely used it for coping. And I started smoking again after Iraq which I shouldn't have done. I didn't do it at home though I'd go back to the barracks. I'm not smoking or drinking now though, nothing at all" Andy, L60-62*

For other participants, the categorisation highlighted the loss of identity and of attributes that they previously valued:

> *"Yeah she's very much like me, she erm, she's a joker, she doesn't take anything serious. Well that's how I used to be" Tom L660-661*

Putting on a front. All participants discussed a process of concealing emotions, thoughts and behaviour, both within the military and in their later transition, often triggered by feelings of shame and fear. In particular participants talked about the stigma of mental health difficulties within the military and the culture of "putting on a façade" (Tom, L167). Tom talked

about feeling that the military as an organisation did not acknowledge the presence of PTSD in its personnel:

> *"Well…it said it all…they said that they'd sent me home on early R&R…cause that's what they told everybody…so that was like…that's them there saying he's alright…he needs to go back sort his head out and he'll be back. So that was them denying that there was anything wrong with me" Tom, L267-270*

Dale discussed a parallel process whereby he and his mum, his main carer, would attempt to conceal their distress to protect each other:

> *"You know what I mean, mum's as hard as stone like. She's got to be strong for me hasn't she. I used to have to be strong for her too though so I wouldn't tell her nothing. We were both trying to keep a stiff upper lip for each other." Dale, L404-408*

All participants suggested that they concealed feelings and experience due to the feared consequences of not doing so. It is likely that the feelings of shame arose due to the dichotomy between their own experiences and the masculinity and emotional inhibition that forms the basis of the military identity.

> "*Like at the funeral they said before we went they said no tears, there's cameras there, keep your dignity at all times and this is a good mate, this is a brother here and you know, I think I did cry actually." James L593-596*

Disconnection

This theme explores the detachment that veterans experienced both from the self and from others.

Disconnection from the self. The men collectively described a disconnection between their current self and the self that that they had expected to be. They reported a loss of future self as a result of discharge, representing low levels of psychological connectedness. Some participants

spoke about the contrast between their discharge and the career that they had expected to have:

> *"Going through a job that I thought was going to be my life, as I thought I was going to be in for the full 22, to go from that to nothing. I had no money, no job, being told I've retired and I can't work or nothing. That was it" Billy, L413-417*

> *" Yeah I really want to stay in. I would have gone on tours until I was 55 and I was too old. That's what I wanted" Andy, L103-104*

More specifically Tom described his disappointment that he was not "compensated" (L400) for the rank that he should have achieved. This is likely to have impacted on his sense of self as well as having financial implications:

> *"That you've got all of these reports saying yeah this man will be, this man be, this man will be. But actually when it comes to the crunch…no we will finish you at that rank there. Well no…that's the rank that I was…So yeah, then you're fighting the system again. It seems like it's a constant battle with 'em." Tom, L408-412*

Dale discussed the disconnection to the body as a result of physical injury:

> *"It was hard because I couldn't do anything for myself. My arm was just…stuck to me in like a sling. I couldn't do nothing for myself. So I went from being a young lad who thought he could take on the world to….mums got to bath me in the morning, mums got to cut my food up for me, mums got to help me get dressed. It's hard." Dale, L394-400*

The disconnection between the actual and expected self appeared to lead to states of powerlessness and helplessness that further enhanced feelings of shame.

Disconnection from others. Upon returning to civilian life, most veterans felt disconnected from people at home and from their previous peers within the military. Dale described the impact of his discharge on his relationship with his partner:

> *"I was with my ex for about 3 and a half years before we split up last year. We were going on different paths and stuff; she was going to uni and she's a lawyer now. She couldn't come to terms with that had happened in the army, she didn't want to go near me or nothing. I think it was because I was different, I had changed, I wasn't the guy she fell in love with." Dale, L170-175*

It was difficult for partners and families to appreciate the experiences within the military and participants felt that others lacked understanding. This was perpetuated by the lack of resources that families received to understand mental health:

> *"They just give you little pamphlets and you can give it to your spouse. It says they may experience this in the next couple of days. But this just puts your family on egg shells because they don't wanna talk to you because you've experienced such and such and they don't know how to approach you." Charlie, L366-370*

Participants also emphasised the impact of PTSD on their relationships:

> *"Well I sleep in different beds from the Mrs due to the night sweats and the dreams and the flashbacks. You just learn yourself to wake up before a dream but then you couldn't sleep and then it all progressed from that over time." Andy, L18-19*

Most participants experienced little or no contact with their military peers after discharge. For some this was a way of distancing themselves from the institution that they had felt rejected by. Other participants found contact with their peers distressing and were reminded of traumatic experiences during their military careers, at times causing flashbacks. Participants also described difficulties within civilian friendships that arose from differing attitudes and values:

> *"I went home but I couldn't stand being at home because my partner, my friends everyone was just so undisciplined." Billy, L87-89*

The Will to Live

This theme captures the ability and drive of veterans to survive and live after suffering a wide range of traumatic experiences.

Buffering the self. After experiencing a threat to their self-esteem, most participants attempted to enrich the self in order to enhance their self-concept. Some participants demonstrated this through their descriptions of the skills that they have achieved since leaving the service:

> *"I tried to go through private investigative firms because I'm a level six investigator, and a police officer is only trained to level 3, so you can imagine how trained I am. I've done all the certificates." Billy, L524-526*

This form of social comparison is likely to have served the purpose of increasing self-esteem following difficulties seeking employment. Tom employed this method by highlighting his successful career within the military:

> *"You know I was…I was flying….I was going to be a Sergeant Major I was going to be a RSM you know" Tom, L402-403*

Attempts at self enhancement were also seen in the types of jobs that participants sought after discharge:

> *"I had drifted into a bit of that sort of violence anyway. You know like I did door work and a bit of close protection and anything like that, that was a little bit spicy." James, L344-346*

Coping the only way we know how. This theme includes coping strategies that in traditional civilian societies would be classed as avoidant or maladaptive. It is likely that their function was quite different within the military culture and the personnel instead coped in the only way they knew how. Most participants discussed the culture of alcohol and illegal drugs within the military and their use within the discharge process:

> *"I used in the Army and started using a lot more when I was injured. I got caught by the Army too. They said I was self-medicating which I was – I wasn't doing it to party I was doing it on my own in my room,*

> *trying to stay awake from the nightmares and that. I wasn't going out to the pub or anything, I was doing it on my own in my room." Dale, L65-71*

Like Dale, James also discussed the function of his drinking to suppress and numb his intrusive experiences triggered by the anniversary of the death of a friend:

> *"[I drank] because that time of year, the start of January, that's when it actually happened. I've never been happy with New Years, I've never been comfortable with it. As I say I hadn't had a drink until 2 o'clock and then I just went berserk. I just wanted to get out of it, out of the feelings." James, L556-560*

Other participants chose to take themselves away from other people to develop their resilience and to manage their ongoing mental health difficulties:

> *"I ended up living in the forest for a few weeks. It was alright, quietest time of my life to be honest" Billy, L89-91*

Meaning making. Six participants employed this cognitive strategy to construct less painful interpretations of their experiences. Despite sustaining life threatening injuries that led to their discharge, three participants described themselves as being "lucky":

> *"I was unlucky to get injured but lucky to survive and be here. 2mm off my jugular, if it had hit that I'd be dead. That's how I have to think about it really. That's what I thought with the drugs as well to make me stop that, I've got a second chance." Dale, L290-295*

> *"Luckily enough there was a top neuro surgeon visiting for just 25 hours. Before that there was no one else that could have helped me with the surgery I had. I was lucky that he was there." Billy, L126-129*

Other participants described their discharge and perceived mistreatment as a motivation to better themselves.

> *"I've managed to do college which I couldn't even do before. I've done Uni but jobs won't take me on because of my medical. The police won't take me on because of my handwriting." Billy, L520-523*

James described his role going forward as using his experiences to share and advise other people. Feeling valuable may have increased his sense of self and diverted his focus away from his discharge:

> *"So I think I will always be a veteran but I want people to come to me and ask me about it. I say to them it's not a game – you have to remember that for all the years of fun and laughter on the beaches on some warm distant land….it doesn't really work like that. This is the British army. If there isn't a war to fight they will find one. Some have listened and some haven't.." James, L602-608*

Humour as a shield. Humour is thought to be an adaptive technique that facilitates coping. As well as helping to tolerate distress, humour can also be an altruistic act in helping others to cope better, and can contribute to more positive and rewarding interpersonal experiences. Dale recounted the day in which his mother was told that his arm would need to be amputated and laughed throughout the story. This appeared to be in contrast to the description of his mother's distress later in the interview which "broke my heart":

> *"Well they didn't tell me, they told my mum and she got arrested. She started fighting and hitting the doctor [laughter]" Dale, L430-433*

Billy described "banter" as being a central trait of military personnel and one that reduces distress (Line 224).

> *"It didn't matter if you'd lost your eye, half your head, your limbs, you always had that banter and I used to walk into a room and I was being wrestled by someone who had no arms or legs. He just jumped over this table and all you see is this stumpy man moving towards you and jumping on you and it just makes you think! He's a cage fighter now!" Billy, L215-223*

Billy used humour here to avoid reflecting on the consequences and loss sustained in the military. It also appears to function as building a sense of connectedness with others, particularly those who have had similar experiences.

Reaching out for help

This theme encapsulates veterans' experiences with agencies from discharge through to support in the civilian community.

Rejection by the military: There's the door, cya later! All seven participants described feeling rejected by the military following medical discharge. Most veterans acknowledged that their expectations of support did not match with the reality and this resulted in strong feelings of "bitterness and anger" (Eric, 176):

> *"They just said that's it, you're medically discharged. Thank you and goodnight." James, L194-196*

> *"And then you're just cast aside like a …like a stray dog…"Tom, L587*

> *"Not enough is done. Veterans are just forgotten." Andy, L336*

Tom spoke about the discrepancy between the services that veterans had provided and the support that was offered by the military:

> "You've given them everything. You sign on that line to say you're…you will give your life if you need to. And they won't look after you afterwards. Yeahhh...that's the bitter pill that you've got to swallow." Tom, L429-431

Billy felt that the military were unsupportive of his attempts at seeking employment and was unable to communicate with his peer group after leaving:

> *"I think it was part of the MOD but as soon as the dotted line comes up it's like they cut all ties with you straight away. I've tried to get in touch with the battalion but I couldn't get in touch with them. I've tried to speak to them for references, for jobs and everything." L285-290*

It is likely that participants felt a sense of betrayal from the organisation and culture around which the majority of their adult life had been based. This further added to their distress and sense of disconnection from others.

"Pushed from pillar to post": Experiences of help seeking post military. Most veterans reported negative experiences seeking help from civilian services for both their mental health difficulties and practical needs such as housing and benefits. Veterans suggested that professionals often misunderstood their difficulties which further increased their feelings of shame:

> *"I tried to get help. I went to see a psychiatrist and she erm said due to some of the stuff that I told her, she asked if I was a homosexual. So I didn't see her again. But there's nothing I can say or do about it now. No one will get sacked." Eric L182-185*

Billy felt that his needs were minimised due to his lack of physical injuries, thus further perpetuating the stigma of mental health difficulties:

> *"He looked me up and down and said well I expected you to be in a wheel chair. As I look at you I can see you are 22 and you can walk and therefore I can't do anything for you and walked off. Later on I had to go for a medical to push for it, with the job centre. I remember waiting for like half an hour, I went in to see the doctor and he said well you are walking and talking "cya later". Billy 312-319*

Andy suggested that the poor mental health provision for veterans was associated with a lack of funding:

> *"As soon as they hear you're a soldier that's it, they don't wanna know even though Cameron says we get priority treatment if its linked to military service. Well that is a load of bollocks. I think it's all to do with money again. It's going to cost a lot of money to treat a person with PTSD and they know there's a bomb shell out there that's going to happen. And it's all going to cost money to treat us all." Andy L356-362*

The participants felt helpless in seeking support which possibly parallels their experiences within the process of discharge, adding further distress to their ongoing poor mental health.

"It's about education": Future service provision. All participants were forthcoming in their suggestions for service provision and this possibly relates to their sense of meaning making and comradery towards other military personnel. They highlighted their eligibility for resettlement packages although no participants were successful in being provided with one:

> *"Normally people get 2-4 resettlements, I think it is, they get a load of cash, they do courses. I've got nothing, no respite. Knowing I've come back from all the action. Billy, L471-477*

Charlie highlighted the importance of having a veteran peer to assist him through the transition. This reciprocal support appeared to reduce feelings of disconnection, possibly due to his veteran status and identity:

> *"We both supported each other, he supported me and I helped him. He had a lot of problems with his Mum and she died a few months ago. So I had to help him out and then he let me talk about any grievances I had." Charlie L227-234*

As well as help for the veterans themselves participants emphasised that more support should be available for the families of those affected:

> *"But for families and stuff like that, they need to be educated as well for them…you know to witness the signs that somethings wrong, there should be something for them to go and speak to confidentially" Tom, L554-559*

Dale said that the timing of support was also important and suggests that recognising mental health should be a shared responsibility:

> *"Like the 1-2-1 sessions that you get for 6 months. They should understand that my head's up my arse. Lads that get injured are just missed. I think the lads just need a bit of time and that. They need to know what the signs and symptoms are. I've noticed it in a few Army*

mates, I've noticed in them straight away. Because like I've learnt about it and now I can notice it in them straight away." Dale, L497-508

Discussion

The aim of this research was to explore the experiences of medical discharge and the process of transitioning to civilian life in a sample of British veterans with PTSD. A purposive sample of seven veterans were interviewed and interpretation led to the development of four super-ordinate themes: identity; disconnection; the will to live; and the journey to help. Few studies have examined the transition to civilian life using qualitative methods and to the best of the author's knowledge this is the first to have explored this with veterans who have left the service via medical discharge.

Main findings and theoretical implications

Although research has indicated that the majority of veterans are successful after leaving the military (Iverson et al, 2005) the results from the current study suggest that there is an additional group of service leavers who experience a more problematic adjustment. To the author's knowledge this is the first study that focuses specifically on those leaving via medical discharge, and it could be hypothesised that these difficulties are exacerbated by the way in which they leave.

The results suggest that the process of leaving the military caused challenges to identity for all veterans, but there were marked differences in how participants responded to this. Some participants made attempts to reconnect with their peers and the Army in order to strengthen their threatened military identity. Other participants made attempts to distance themselves from the military in order to cultivate their civilian identity. Some described feeling in "limbo" between the two identities (Charlie, line 94). Social Identity Theory (SIT) proposes that the groups to which people belong provide an important source of pride and self-esteem (Tajfel & Turner, 1986). Groups provide a sense of social identity: a sense of belonging to the social world.

Within the armed forces the construct of social identity can be viewed as a mechanism to reduce individualism and to support obedience and conformity. First names are removed, uniforms are worn, and the high standards of conduct and grooming are regulated and enforced. In line with SIT the military becomes the in-group for service personnel and civilians form the out-group. Some participants described feeling superior to civilians, with one describing them as “second class citizens” (James, L215). Discriminating and holding prejudiced views against the out group, in this case civilians could be seen as a method of enhancing ones self-image.

When service personnel left the military they often described feelings of shock, betrayal and confusion. Some participants responded by negating the changes in groups and instead emphasised their “ingrained” military identity (James, L604). In contrast to this, some participants distanced themselves from the military and this could be seen as them making civilians their new in-group. In line with SIT the transition is likely to have caused a threat to their self-esteem and may have also contributed to the methods of coping discussed below.

All participants reported feeling disconnected from both themselves and others, which supports previous research by Ahern et al. (2015). Participants described feeling “different” (e.g. Billy, Line 138) from their friends and family back home. This level of disconnection may be due, in part, to their lack of shared experiences (Crawford, 1996). Participants also described feeling a disconnection with the self, possibly generated by a loss of future self, due to changes in expected health, role, career, financial position and employment. Research suggests that disconnection in this form can inhibit decision making and increase impulsivity, possibly leading to more difficulties during the transition (Urminsky, 2016).

Shame and stigma appeared to increase the disconnection that was reported. Shame is described as a global, negative affect in which the self is painfully scrutinised and negatively evaluated (Lindsay-Hartz, 1984; Tangney, 1989). It is often accompanied by a sense of worthlessness and powerlessness (Wicker et al., 1983). All participants described feelings of

shame throughout their interviews. Some participants felt shame that they were unable to perform their duties as active servicemen whilst others felt shame towards their mental health difficulties. These findings support the work by Rona et al (2009) and can be understood in terms of the wider military culture. It is well documented that a proportion of service personnel experience psychological problems from their experiences within the military, but there appears to be a disparity between this figure and the number who seek help for their difficulties (Britt, 2007). Britt (2010) examined the stigma associated with psychological difficulties among members of the United States armed forces. The disclosure of psychological difficulties was perceived as more stigmatising than medical problems, and service personnel were less likely to accept a psychological referral than a medical referral. Similarly, Hoge et al. (2004) found that of those personnel with mental health difficulties, only 38 to 45% indicated an interest in receiving help, and this subgroup were twice as likely than their peers to report fear of stigmatisation.

Participants displayed a variety of coping strategies, that appeared to have been functional throughout their military careers, and this continued into their transitions. Coping occurs in response to psychological stress, often triggered by change, and reflects an attempt to maintain mental health and emotional well-being (Lazarus & Folkman, 1984). Coping strategies are the thoughts, emotions and behaviours that manage internal and/or external demands in a stressful encounter (Folkman & Lazarus, 1988). The literature highlights two main coping strategies: problem-solving strategies involving active efforts to alleviate stressful circumstances; and emotion-focused coping strategies which involve efforts to regulate the internal emotional experience. Folkman and Lazarus (1980) suggest that people use both types of strategy and the preference is mediated, in part, by an individual's temperament and the nature of the situation that they are facing. Coping is also identified as being either active or avoidant. Active coping refers to behavioural and cognitive attempts to manage and change a stressful situation and includes strategies such as problem-solving, cognitive restructuring and seeking information (Kotze, 2013). In contrast to this,

avoidant coping employs behavioural and cognitive strategies to avoid dealing with a stressful situation with the use of, for instance, distancing, denial and distraction. The latter form of coping has also been compared to Freud's early theories of ego-defenses; defense mechanisms that operate at an unconscious level and prevent the surfacing of difficult feelings such as anxiety (Freud, 1937; Robinson, 2005).

Participants described employing a combination of coping strategies that varied throughout their journey of adjustment. The men described using alcohol and drugs to suppress difficult emotions and thoughts and this could be viewed as an avoidant coping strategy. On the other hand some participants described using drugs as a stimulant and to avoid PTSD symptoms such as night terrors. This could be viewed as a more active coping strategy with participants making behavioural attempts to manage the distress in a preventative fashion. Some research has suggested that the relationship between coping styles and well-being is cultural and situation specific, with research demonstrating a positive relationship between avoidant coping strategies and lower levels of depressive symptomatology (Mosher & Prelow, 2007). It is important to acknowledge the culture of the armed forces and the coping strategies it may encourage. It could be argued that during the acute distress of trauma and discharge the participants reverted to the avoidant coping styles that had been reinforced throughout their careers, and one that distanced them from their intolerable distress.

Participants shared stories that emphasised the positives of their journey, often referred to in narrative therapy as a process of meaning making (White & Epston, 1990). During the interviews it was notable that most participants made attempts to present a positive image of themselves and this could be understood in terms of theory relating to self enhancement. Self-enhancement involves a preference for positive over negative self-views (Sedikides & Greg, 2008) and is especially prominent in situations of threat or failure (Kruger, 1998). Some participants described themselves as associating with others of elevated social status which reinforced their own status as being above others (Tom, L478). One participant described his hierarchical views of the world, placing serving personnel and veterans at the

top (e.g. Andy, L120-124). Self enhancement has been shown to impact positively on mental health (Taylor, Lerner, Sherman, Sage & McDowell, 2003) although other studies have suggested that it can decrease social adaption and impact negatively on relationships (Bonanno, Rennicke & Dekel, 2015).

Clinical Implications

The findings from this study have important implications for those planning and commissioning service as well as those working on an individual basis with veterans.

The NICE guidelines state that trauma-focused Cognitive Behavioural Therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) should be offered to individuals with PTSD. The current study suggests that other models, such as Narrative Therapy, could also be beneficial to veterans to help them process and explore their experience of leaving the military. Core values and identity are at the centre of this therapeutic approach and the technique of ‘re-authoring the story’ may provide support and validation for veterans in making sense of their transition (White, 1995). It will be important for clinicians to consider the difficulties engaging this client group, and barriers to help seeking such as a military-civilian divide. Clinicians would benefit from developing their knowledge of military systems and processes to aid this.

For some participants the process of discharge appeared to be traumatic in itself and this is likely to have exacerbated their mental health difficulties and ability to manage the process of transition. Both pre and post discharge there appears to be a lack of psychoeducation and efforts should be made to educate both veterans and their families on PTSD and mental health. Improved screening of mental health difficulties would also assist in early detection and signposting to appropriate services. In the current study one participant talked about the positive support that he received from a peer who had also left the military, and this supports previous research by Ahern et al (2009). Veterans may find it helpful to be matched with a peer navigator (e.g. someone who has successfully navigated the discharge process and

integration into civilian society) and this may increase the feelings of connectedness that are reportedly lacking.

The results of the current study suggest that mental health difficulties continue to be stigmatised within the military and thus suggests that changes are needed on the systemic as well as individual level. Feelings of shame and stigma are likely to be exacerbated by the feeling of rejection experienced from both military and civilian health provisions. Interventions should therefore address both societal and self-stigma. Britt (2007) suggest that military leaders or personnel of senior ranks should be instrumental in identifying and assisting service members needing help for mental health difficulties. Future research is needed to investigate whether such initiatives can reduce barriers to help seeking. It is also important to highlight the finding that many service personnel reported “putting on a front”, further increasing the difficulties of accurate detection.

Strengths and validity

The core principles proposed by Yardley (2000) for assessing the validity of qualitative research will each be presented here in turn:

Sensitivity to context. The researcher developed a grounding in the philosophical and epistemological values of IPA through extended reading. Awareness of the socio-cultural setting of the study was developed through supervision, visits to Combat Stress and through discussion with experts in the field. The researchers own personal relationship with the military was considered throughout. Care was taken in interactions with participants to foster a rapport whilst being mindful of power imbalances.

Commitment and Rigor. Immersion in theoretical and empirical data by the researcher. The selected sample size was in line with guidelines by Smith et al. (2009). All interview transcripts were explored in supervision and an IPA group to ensure reasonable interpretations of the data.

Transparency and Coherence. This was demonstrated via the inclusion of photographs and detailed information of each stage of the research process (appendices L-Q). Depth and breadth are indicated by the

inclusion of extracts from each of the seven participants. Personal and epistemological reflexivity are explored.

Impact and Importance. To the researchers knowledge this study is the first one to investigate the experience of the transition from the British armed forces, via medical discharge, in a sample of veterans with PTSD. Clinical implications and paths for future research are discussed. The results will be shared within Combat Stress and the researcher has also been invited to present the findings at Kings Centre for Military Health Research.

Limitations and future research

The study employed opportunity sampling of veterans and consequently the recruited sample were all male and had served within the British Army. This gender bias may have implications when generalising the findings to growing number of female veterans, and also those personnel from other military services. Future research should therefore aim to explore the transitional experiences within wider samples.

It is also worthy to consider the gender of the researcher and their status as a civilian. In contrast to the participants the researcher was female and due to their social group, may have been viewed as a “second class citizen” (James, L215). Previous research has suggested that the lack of shared knowledge with this client group may impact on the researchers’ ability to develop a working rapport and elicit responses of appropriate depth (Brunger, Serrato & Ogden, 2013).

Whilst much has been written about veterans from the American and Canadian armed forces, very little research has focused on the experience of their British colleagues (Iversen et al., 2005). The challenges facing the UK military service-leavers are inadequately reflected in the literature and require further attention in order to better develop support and services that best meet their needs (Sondergaard et al., 2016). Future qualitative research is needed to explore the experiences of British veterans during transition and these should attempt to recruit wide ranging participants across the services.

Conclusion

Overall, it is critically important to better understand and assist veterans in their transition from the armed forces. The current research suggests that some veterans leaving the military by medical discharge do not feel supported in their transition and have significant difficulties adjusting into civilian society. Further research needs to consider how to support this subgroup of veterans, and more qualitative methodology is needed to explore these individual experiences. Given the pervasive feeling of disconnection and shame, it is also important to develop ways to foster reconnection between veterans and their support systems, and to reduce the barriers to help seeking both pre and post discharge.

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Paper 3: Reflective Paper and Commentary

This paper is not intended for publication

Reflective Paper and Commentary

Reflective practice

In the health profession reflective practice is regarded as an essential characteristic for professional competence (Mann, Gordon & Macleod, 2009). Lucas (1991) defined reflective practice as a systematic enquiry to develop and deepen our understanding of practice. It is also a process that involves the application of theory to professional practise (Thompson, 2000). Bassot (2015) proposed eight key aims of professional practice: to provide a space for deep thinking; to evaluate and develop practice; to prevent stagnation; to strive for excellence; to make practice creative; to improve self-awareness; to suspend assumption making; to provide an aid for supervision; and to provide a means for constructing professional knowledge. Papers one and two have focused on the journey of veterans leaving the armed forces and the following paper will reflect upon my journey undertaking the doctoral thesis. I will share my reflections upon designing the research project and the veterans that I had the opportunity to interview. I will explore the challenge of being in the role of researcher rather than therapist, and my own personal connections with the military. Finally I will conclude with the key learning points that I have taken from the doctoral thesis. Due to the reflective nature it will be written using first person.

The beginning: Selecting a research topic

Unlike some of my fellow trainee colleagues I did not have a research idea upon joining the course and I spent a lot of time in the first year considering this. It was important not only to carry out a piece of research that was clinically relevant but also something that held meaning to me. I was aware that I would be dedicating a considerable amount of time to the thesis and it was therefore important that the project held meaning for me. Prior to starting on the doctorate course I was employed as an assistant psychologist at a high secure hospital. I worked primarily on the intensive care ward and was struck by the enduring impact of trauma that every client appeared to present with. It was during this role that my interest in trauma really began.

As well as a professional interest in trauma I also had personal links to the military; my fiancé was a serving member of the Royal Air Force as a Parachute Jump Instructor. Through our discussions over the tea table and meeting his friends and colleagues I began to consider more deeply the impact that military life has on an individual. It seemed to be such a core part of their identity; what happens to that part of them when they leave I wondered? I heard stories about the horrendous experiences that these men and women were subjected to, often on deployments, but not exclusively. On one occasion my partner was away and involved in a parachuting incident in which a good friend suffered from life changing injuries. I heard about the devastating impact that trauma had on the individual and how this impacted on the people that were involved. I saw comradery that I had not seen before. I wanted to know more about these men and women's experiences. I wanted to help share the voices of the heroes that only too often get muted and forgotten.

Surrendering control

Throughout the research project I found the lack of control that I had over the process particularly anxiety provoking. In order to feel more "in control" I started to think about my thesis quite early on in the course and approached Combat Stress at the start of my second year on training. I met with Charlie Johnson (Senior Clinical Psychologist) and we had some exciting conversations about the work that Combat Stress carried out and my initial research ideas. Her enthusiasm really helped to reassure me and motivated me to narrow down my ideas. Initially I developed a proposal for a quantitative project that was focused on early maladaptive schemas and PTSD. I submitted this early and achieved University ethical approval with no difficulties. Despite this the project did not receive ethical approval from Combat Stress. I felt panicked and disheartened at this point and felt stuck for a number of weeks. Throughout this Charlie facilitated several supervision sessions and helped to contain some of my anxieties. I went back to my early thoughts about trauma and PTSD and through extensive literature searching I noticed that there was a real lack of research that focused on experiences. Although my original proposal had been a

quantitative piece of research I began to consider a qualitative approach to achieve more depth in my project. My initial scoping reviews highlighted a lack of research in this area. There was a wealth of research into PTSD and prevalence rates (Hines, Sundin, Rona, Wessely, & Fear, 2014) and multiple sources that demonstrated that a substantial proportion of people with PTSD went on to leave the military (e.g. National Statistics, 2016b). I noticed that there was a lack of qualitative research as a whole and even less qualitative research into veterans' experiences once they had left the military. To my knowledge there was no published research into the experiences of veterans who had been medically discharged.

Carrying out the research: The participants

Most of the men that participated in the study expressed their thanks that the researcher was taking the time to work with and understand the experiences of veterans. This was in contrast to their earlier experiences of feeling misunderstood and not listened to. On the one hand this increased my anxiety as I was aware how let down this client group had been and it was important to me that I didn't replicate their experiences. However having this positive feedback was also motivating and it was helpful to be reminded of this, particularly during periods when the thesis felt overwhelming.

From completing extensive literature searches for both my literature review and empirical paper I was also aware of the divide that military personnel report between themselves and civilians. As well as being classed as a civilian I was employed by the NHS; a system that most reported feeling let down by and frustrated towards. Although participants were aware of my links with the NHS I chose not to wear my NHS name badge during interviews in an attempt to manage the tensions and power imbalance. During the interviews I was also mindful of the reported stigma of mental health difficulties within the military (Rona et al, 2009) and although I chose to ask questions around this, I did so sensitively. Pride and shame may have inhibited the sharing of information within the interviews and may also have impacted on a veteran's decision to participate in the study. This is a

limitation of the current study and should be considered with future research with this client group.

Data was collected from Combat Stress and all participants on the Intensive Treatment Programme for PTSD were invited to participate and given information on the study. I had hoped to recruit both male and female veterans but unfortunately the one female that consented was too unwell to participate on the day of her interview. I considered the gender differences in relation to the emergent themes and hypothesised that there may have been differences in the coping strategies that female veterans reported, as well as help seeking behaviours and protective factors. The lack of female veterans is also reflected in the literature: little is known about the experiences of female veterans. This may be in part due to the demographic make-up of the Armed Forces but it is important to consider alternative reasons. In my reading around the military I came across the Help for Heroes website and was disappointed to see the following tagline – “80p in every pound is spent helping the blokes”. I reflected upon how female veterans would interpret this statement, and wonder if it would further stigmatise mental health and inhibit them from seeking help. As well as further research with female veterans it is clear that changes are needed in the wider field.

Inner conflict: Therapist versus Researcher

Due to limited experience with qualitative research methods I initially felt anxious in the first participant interviews and this is likely to have impacted on the flow and timing of my questions: this limited experience could be considered as a methodological limitation. As my familiarity with the interview process grew however, so did my confidence and I noticed that I had ‘entered the participant’s world’ (Smith et al. 2009, p. 42), known as the double hermeneutic (Smith & Eatough, 2006). Whilst this underpins IPA methodology I noticed that engaging on this deeper level also connected me to participants on an emotional level. I noticed that at times when participants were sharing emotive stories I also began feeling a similar emotion, often sadness. This could be interpreted as counter-transference; a term used in psychodynamic psychotherapy which describes the feelings a clinician

experiences towards a client (Malan, 1995). On these occasions I felt confusion between my role as a researcher and a therapist. I noticed this occurred when participants were experiencing both positive and negative emotional states. This presented me with a dilemma as my therapy training was urging me to engage in a therapeutic dialogue to contain their distress. This reflects the challenges that can arise in acting as both a scientist and practitioner (Beutler, Williams, Wakefield & Entwistle, 1995). I did notice that as the interviews progressed I was able to contain my own responses and the participant's emotions, without using a therapeutic dialogue. The use of supervision and a reflective journal was important in developing this resilience.

Personal reflexivity: My own relationship with the military

As previously stated, my partner was a serving member of the Armed Forces and during the final period of data collection and write up he was deployed overseas for six months. This provided a number of challenges. My partner was my main source of support and it was therefore important that I adapted to this and sought out alternative sources of support, particularly during stressful periods of the thesis journey. I also noticed at times that I identified more with a military identity than a civilian one and it was important to acknowledge my role as a researcher within the write up on my papers. It was also important to discuss this within supervision and to explore my findings with other clinicians to improve the rigor of the study and to ensure reasonable interpretations of the data. It was also important to ensure that I maintained my interests outside of my thesis, such as crafting and running, to look after my own well-being.

Within the interviews I considered whether to share my own connections to the military. I expected this disclosure to improve the engagement and rapport and previous research has suggested that military personnel prefer to work with professionals with experience of the military culture (Brunger, Serrato & Ogden, 2013). Nevertheless Smith, Flowers and Larkin (2009) suggest that the researcher should take a neutral position and ask open-ended questions within the interview. I therefore made the decision not to

disclose my personal links with the military. Instead I focused on the engagement part of the interview and attempted to put participants at ease by using a warm and empathetic communication style. The interview schedule was designed with this in mind and the initial questions were of a more general nature to allow the relationship to develop.

The Future: Life after the DClinPsy

Although my thesis journey has felt long, and at times challenging, it is one that I have enjoyed and developed greatly from. I have gained a much greater appreciation for the real life applications of research, particularly when there are gaps in the literature. I have experienced first-hand the challenges of designing and implementing research within mental health services, from ethics proposals to disseminating findings. I have a new appreciation for the depth that can be achieved with qualitative methods and hope that employment post qualification will allow me to develop these skills further.

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Appendix A: Journal of Aggression, Conflict and Peace Research

Submission guidelines

Journal of Aggression, Conflict and Peace Research (JACPR) is unique in providing collective coverage of these often separated disciplines. This approach stems from the ethos that in order to understand conflict and aggression it is also necessary to understand peace and conflict resolution (and visa versa).

JACPR publishes a broad range of peer-viewed and international original articles and review papers on all aspects of aggression, conflict and peace. It is aimed at both academic and practice development with a clear remit of translating research findings and policy into implementations for practice.

JACPR stands out in the marketplace for its broad and multidisciplinary scope, encompassing topics such as physical and sexual aggression, from individual violence to mass aggression, including genocide and terrorism. It also investigates the dynamics and evolution of conflict and resolution and explores peace research.

JACPR is published in association with the University of Central Lancashire and Ashworth Research Centre.

"[Journal of Aggression, Conflict and Peace Research] is a fairly recent journal that publishes high-quality work and that has already begun to attract an international following, as evidenced by the growing citation history. An obvious candidate for inclusion in Scopus." Scopus Content Selection & Advisory Board (CSAB), 2013

This journal is abstracted and indexed in:

EBSCO Criminal Justice Abstracts, Emerging Sources Citation Index (ESCI), Illustrata, International Security & Counter-Terroism Reference Center, PsycINFO, ReadCube Discover, Scopus

This journal is ranked by:

Scopus and Database for Statistics on Higher Education, Norway (Level 1)

<u>Author guidelines for submission:</u>

- Articles should not exceed 6,000 words
- Articles should include no more than two tables/figures

Appendix B: Crowe Critical Appraisal Tool (CCAT; Crowe, 2013)

Category Item	Description	Score [0–5]
Preamble		**Preamble**
Text	1. Sufficient detail others could reproduce ☐ 2. Clear/concise writing ☐, table(s) ☐, diagram(s) ☐, figure(s) ☐	
Title	1. Includes study aims ☐ and design ☐	
Abstract	1. Key information ☐ 2. Balanced ☐ and informative ☐	
Introduction		**Introduction**
Background	1. Summary of current knowledge ☐ 2. Specific problem(s) addressed ☐ and reason(s) for addressing ☐	
Objective	1. Primary objective(s), hypothesis(es), or aim(s) ☐ 2. Secondary question(s) ☐	
Design		**Design**
Research design	1. Research design(s) chosen ☐ and why ☐ 2. Suitability of research design(s) ☐	
Intervention, Treatment, Exposure	1. Intervention(s)/treatment(s)/exposure(s) chosen ☐ and why ☐ 2. Precise details of the intervention(s)/treatment(s)/exposure(s) ☐ for each group ☐ 3. Intervention(s)/treatment(s)/exposure(s) valid ☐ and reliable ☐	
Outcome, Output, Predictor, Measure	1. Outcome(s)/output(s)/predictor(s)/measure(s) chosen ☐ and why ☐ 2. Clearly define outcome(s)/output(s)/predictor(s)/measure(s) ☐ 3. Outcome(s)/output(s)/predictor(s)/measure(s) valid ☐ and reliable ☐	
Bias, etc	1. Potential bias ☐, confounding variables ☐, effect modifiers ☐, interactions ☐ 2. Sequence generation ☐, group allocation ☐, group balance ☐, and by whom ☐ 3. Equivalent treatment of participants/cases/groups ☐	
Sampling		**Sampling**
Sampling method	1. Sampling method(s) chosen ☐ and why ☐ 2. Suitability of sampling method ☐	
Sample size	1. Sample size ☐, how chosen ☐, and why ☐ 2. Suitability of sample size ☐	
Sampling protocol	1. Target/actual/sample population(s): description ☐ and suitability ☐ 2. Participants/cases/groups: inclusion ☐ and exclusion ☐ criteria 3. Recruitment of participants/cases/groups ☐	
Data collection		**Data collection**
Collection method	1. Collection method(s) chosen ☐ and why ☐ 2. Suitability of collection method(s) ☐	
Collection protocol	1. Include date(s) ☐, location(s) ☐, setting(s) ☐, personnel ☐, materials ☐, processes ☐ 2. Method(s) to ensure/enhance quality of measurement/instrumentation ☐ 3. Manage non-participation ☐, withdrawal ☐, incomplete/lost data ☐	
Ethical matters		**Ethical matters**
Participant ethics	1. Informed consent ☐, equity ☐ 2. Privacy ☐, confidentiality/anonymity ☐	
Researcher ethics	1. Ethical approval ☐, funding ☐, conflict(s) of interest ☐ 2. Subjectivities ☐, relationship(s) with participants/cases ☐	
Results/Findings		**Results/ Findings**
Analysis, Integration, Interpretation method	1. A.I.I. method(s) for primary outcome(s)/output(s)/predictor(s) chosen ☐ and why ☐ 2. Additional A.I.I. methods (e.g. subgroup analysis) chosen ☐ and why ☐ 3. Suitability of analysis/integration/interpretation method(s) ☐	
Essential analysis	1. Flow of participants/cases/groups through each stage of research ☐ 2. Demographic and other characteristics of participants/cases/groups ☐ 3. Analyse raw data ☐, response rate ☐, non-participation/withdrawal/incomplete/lost data ☐	
Outcome, Output, Predictor analysis	1. Summary of results ☐ and precision ☐ for each outcome/output/predictor/measure 2. Consideration of benefits/harms ☐, unexpected results ☐, problems/failures ☐ 3. Description of outlying data (e.g. diverse cases, adverse effects, minor themes) ☐	
Discussion		**Discussion**
Interpretation	1. Interpretation of results in the context of current evidence ☐ and objectives ☐ 2. Draw inferences consistent with the strength of the data ☐ 3. Consideration of alternative explanations for observed results ☐ 4. Account for bias ☐, confounding/effect modifiers/interactions/imprecision ☐	
Generalisation	1. Consideration of overall practical usefulness of the study ☐ 2. Description of generalisability (external validity) of the study ☐	
Concluding remarks	1. Highlight study's particular strengths ☐ 2. Suggest steps that may improve future results (e.g. limitations) ☐ 3. Suggest further studies ☐	

Appendix C: Quality Appraisal Results for Quantitative Studies

Crowe Critical Appraisal Tool (Crowe, 2013)

Category	Thompson et al, 2013	Black & Papile, 2010	VanDen-Kerkhof et al, 2015	Wolfe et al, 1993	MacLean et al, 2014	Staden et al, 2007
1. Preamble /5	3	4	4	4	3	3
2. Introduction /5	3	5	4	4	4	3
3. Design /5	2	3	2	3	3	3
4. Sampling /5	4	1	3	2	3	3
5. Data collection /5	1	3	2	3	1	3
6. Ethical matters /5	1	0	2	1	0	2
7. Results /5	4	4	4	3	3	3
8. Discussion /5	5	4	4	3	4	4
9. Total /40	23	24	25	23	21	24
Combined Total %	57.5	60	62.5	57.5	52.5	60

Appendix D – Critical Appraisal Skills Programme (CASP)

Adapted from the online version of the CASP

Factor	Supporting Information
Was there a clear statement of the aims of the research? Yes Partially Met No Not mentioned *HINT: Consider* *□ What was the goal of the research?* *□ Why it was thought important?* *□ Its relevance*	
Is qualitative methodology appropriate? Yes Partially Met No Not mentioned *HINT: Consider* *□ If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* *□ Is qualitative research the right methodology for addressing the research goal?*	
Was the research design appropriate for addressing the aims of the research? Yes Partially Met No Not mentioned *HINT: Consider* *□ If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?*	
Was the recruitment strategy appropriate for the aims of the study? Yes	

Partially Met No Not mentioned *HINT: Consider* *□ If the researcher has explained how the participants were selected* *□ If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* *□ If there are any discussions around recruitment (e.g. why some people chose not to take part)*	
Was the data collected in a way that addressed the research issue? Yes Partially Met No Not mentioned *HINT: Consider* *□ If the setting for data collection was justified* *□ If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* *□ If the researcher has justified the methods chosen* *□ If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?* *□ If methods were modified during the study. If so, has the researcher explained how and why?* *□ If the form of data is clear (e.g. tape recordings, video material, notes etc)* *□ If the researcher has discussed saturation of data*	
Has the relationship between the researcher and participant been adequately considered?	

Yes Partially Met No Not mentioned *HINT: Consider* *□ If the researcher critically examined their own role, potential bias and influence during (a) Formulation of the research questions (b) Data collection, including sample recruitment and choice of location* *□ How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Have ethical issues been taken into consideration? Yes Partially Met No Not mentioned *HINT: Consider* *□ If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* *□ If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* *□ If approval has been sought from the ethics committee*	
Was the data analysis sufficiently rigorous? Yes Partially Met No Not mentioned *HINT: Consider*	

□ If there is an in-depth description of the analysis process *□ If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?* *□ Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* *□ If sufficient data are presented to support the findings* *□ To what extent contradictory data are taken into account* *□ Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	
Is there a clear statement of findings? Yes Partially Met No Not mentioned *HINT: Consider* *□ If the findings are explicit* *□ If there is adequate discussion of the evidence both for and against the researchers arguments* *□ If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* *□ If the findings are discussed in relation to the original research question*	
How valuable is the research? Yes Partially Met No Not mentioned *HINT: Consider* *□ If the researcher discusses the contribution*	

the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature? *□ If they identify new areas where research is necessary* *□ If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*	

Appendix E: Quality Appraisal Results for Qualitative Studies

CASP scoring system

Factor No.	Criteria	Bruger, Serrato & Ogden (2013)	Ahern, Worthen, Master, Lippman, Ozer & Moos (2015
1	Clear statement of aims	Y	Y
2	Is qualitative appropriate	Y	Y
3	Is design appropriate for aims	Y	P
4	Is recruitment strategy suitable	P	Y
5	Date collection	Y	Y
6	Role of researcher	Y	NM
7	Ethical issues	P	Y
8	Rigour of data analysis	Y	P
9	Clear statement of findings	P	Y
10	Value of the research	Y	Y

Key	Degree criteria is met
Y	Yes
P	Partially
N	No
NM	Not mentioned

Appendix F: Summary table of papers selected for review

	Title	Study type & aim	Methodology & Participants	Main Findings	Strengths	Weaknesses
Wolfe et al. (1993) US	Patterns of Positive Readjustment in Vietnam Combat Veterans	Quantitative. To identify factors that may have contributed to positive readjustment in a group of heavily combat exposed Vietnam veterans.	Questionnaire design. Purposive sampling. 152 community-based male Vietnam veterans	*A subset of well-functioning veterans with substantial combat exposure were identified – they employed non-avoidant coping styles *Coping strategy predicted current adjustment better than combat exposure	*Addressed limitations of previous research- sample and measures	*Low response rate *Diagnostic assessment methods do not represent rigorous diagnosis of PTSD * Did not assess the degree to which intervening life events influenced current readjustment
Staden et al (2007) UK	Transition Back into Civilian Life: A Study of Personnel Leaving the U.K. Armed Forces via "Military Prison"	Quantitative. To identify the factors associated with poor outcomes for personnel leaving the Armed Forces via the Military Corrective Training Centre.	Longitudinal Random sampling. N=74	*56% of participants at the follow up stage were classed as being disadvantaged *Follow-up disadvantage was associated with having a mental health problem at discharge, having no permanent accommodation to return to on discharge, shorter sentence lengths, and administrative discharge.	*Longitudinal study allowed analysis of the resettlement trajectories of service leavers. *Included a comparison of responders and non-responders at the six month point.	*Contact and follow- up was only achieved for 68% of sample and was limited to 6 months after leaving.

Black & Papile (2010) Canada	Making it on Civvy Street: An Online Survey of Canadian Veterans in Transition	Quantitative. To conceptualize veterans' transitional experiences.	Questionnaire. Purposive sampling. Sample size not clearly specified.	*57.1% described their transition experience as difficult and 37.6% felt that they had not made a successful transition to civilian life	*Research completed independent of the Government *More representative of those veterans that seek help for their transition issues.	*Attrition rate *Biased sample – digital divide
Thompson at al. (2013) Canada	Health-related Quality of Life of Canadian Forces Veterans After Transition to Civilian Life	Quantitative. To describe the HRQoL of veterans, to identify protective and risk factors for HRQoL, and to compare HRQoL to Canadian normative data.	Questionnaire. Stratified sampling N= 3151.	*HRQoL varied across a range of biopsychosocial factors, suggesting possible protective factors and vulnerable subgroups that may benefit from targeted interventions.	* Socio-demographic and military characteristics were objectively identified using DND administrative data. *The Short Form Health Survey has been widely used as a measure of self-perceived HRQoL .	* Indicators of health and disability were determined by self-report. * The SF-12 captures past-month HRQoL which does not correspond to the time frames of many indicators.

Brunge, Serrato & Ogden (2013) UK	"No man's land": The transition to civilian life	Qualitative To explore experiences of the transition from military to civilian life and to identify barriers and facilitators to re-employment.	Semi-structured interviews, IPA. N=11	Master themes: *characteristics of a military life *loss as experienced upon return to civilian life *attempts to bridge the gap between the ‘‘two lives’’.	*lots of suggested implications for practical application *qualitative data to provide rich data in an under researched area	*gender of researcher – inhibited discussion *results not generalisable to wider population - comprised male ex-service personnel of below officer rank.
MacLean et al (2014) Canada	Post-military Adjustment to Civilian Life: Potential Risks and Protective Factors	Quantitative. To identify potential risk and protective factors associated with difficult adjustment.	Questionnaire. Stratified random sampling. Sample size not clearly specified.	*Difficult adjustment to civilian life was 25%. *Statistically significant differences were found across indicators of health, disability, and determinants of health.	*The survey was comprehensive, examining the health, disability, and determinants of health for Canadian veterans living in the general population *Veteran status was identified through objective record linkage, not self-report.	*Findings cannot be generalized to all veterans (they represent regular Canadian Armed Force veterans released from 1998 to 2007) *Many characteristic were self-reported

VanDenKerkhof et al. (2015) Canada	Pain in Canadian Veterans: Analysis of data from the Survey on Transition to Civilian Life	Quantitative. To explore the prevalence of chronic pain in Canadian Veterans and identify potential correlates of chronic pain.	Questionnaire design. Stratified random sample. N= 3154	*41% percent of the population experienced constant chronic pain and 23% experienced intermittent chronic pain. 25% reported pain interference.	*Random sampling and weighting of the sample to the total population improves the generalisability of the findings. *High response rate and high consent-to-share rate reduced the likelihood of response bias.	*Indicators and determinants of health were captured by self-report. *The three questions used to capture pain outcomes do not capture the level of detail available from other validated survey instruments and do not include a measure of pain duration.
Ahern et al. (2015) US	The Challenges of Afghanistan and Iraq veterans' transition from military to civilian life and approaches to reconnection	Qualitative To explore the transition from military to civilian life in Afghanistan and Iraq Veterans' and relating this to Homecoming Theory	Semi-structured interviews, TA. N=24	Overarching themes: *Military as family *Normal is alien *Searching for a new normal *Most common resource for a successful transition was a peer navigator (veteran)	*Sample recruited from wide array of veteran contacts and networks and included veterans from a diverse set of backgrounds and does not over represent care seeking veterans	*Less likely to have recruited veterans who faced more difficulties in transition (as they did not recruit from any health care seeking settings).

Appendix G: Journal of Aggression, Conflict and Peace Research

Submission guidelines

Journal of Aggression, Conflict and Peace Research (JACPR) is unique in providing collective coverage of these often separated disciplines. This approach stems from the ethos that in order to understand conflict and aggression it is also necessary to understand peace and conflict resolution (and visa versa).

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JACPR stands out in the marketplace for its broad and multidisciplinary scope, encompassing topics such as physical and sexual aggression, from individual violence to mass aggression, including genocide and terrorism. It also investigates the dynamics and evolution of conflict and resolution and explores peace research.

JACPR is published in association with the University of Central Lancashire and Ashworth Research Centre.

"[Journal of Aggression, Conflict and Peace Research] is a fairly recent journal that publishes high-quality work and that has already begun to attract an international following, as evidenced by the growing citation history. An obvious candidate for inclusion in Scopus." Scopus Content Selection & Advisory Board (CSAB), 2013

This journal is abstracted and indexed in:

EBSCO Criminal Justice Abstracts, Emerging Sources Citation Index (ESCI), Illustrata, International Security & Counter-Terroism Reference Center, PsycINFO, ReadCube Discover, Scopus

This journal is ranked by:

Scopus and Database for Statistics on Higher Education, Norway (Level 1)

<u>Author guidelines for submission:</u>

- Articles should not exceed 6,000 words
- Articles should include no more than two tables/figures

Appendix H : Staffordshire University Ethics Committee Approval Letter

STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	**Rebecca Lovatt**
Title of Study:	**Beyond Battle**
Status of approval:	**Amendment approved**

Thank you for your correspondence requesting approval of a minor amendment to your application.

Your amended application is approved. We wish you well with your research.

Action now needed:

Your amendment has now been approved by the Faculty's Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

Signed: Dr Peter Kevern **Date: 8/3/16**
Chair of the Faculty of Health Sciences Ethics Panel

Appendix I: Combat Stress Ethics Approval

Hello Becca,

I am pleased to grant approval for your project to go ahead within Combat Stress. Please do keep me informed as it sounds an interesting and valuable study

BW

Dominic

Dr Dominic Murphy

Lecturer in Clinical Psychology

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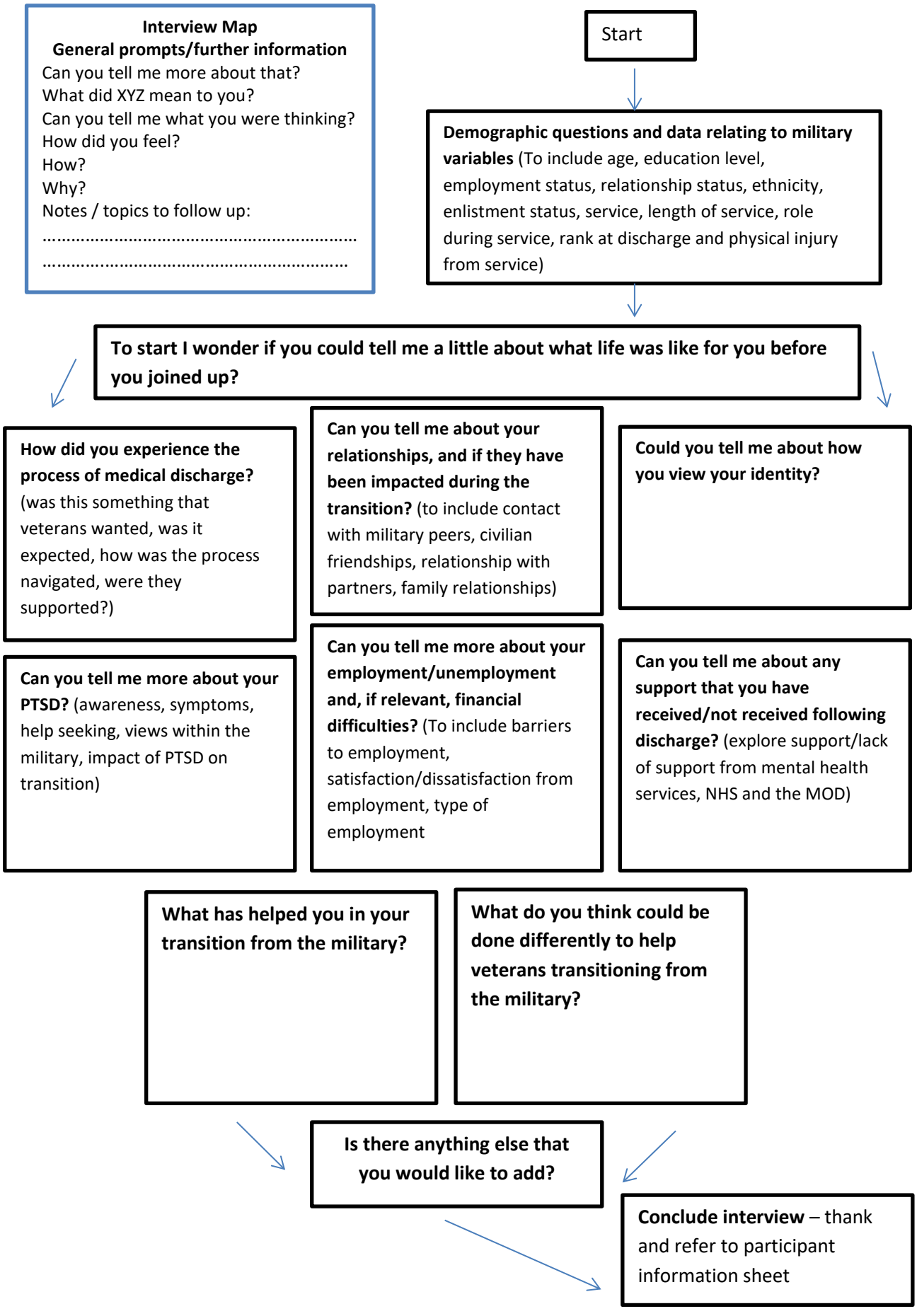
Appendix J: Interview Map



Appendix K: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Study title**:**

Veteran adjustment to civilian life.

Invitation and Brief Summary:

This is a study exploring experiences of military veterans with PTSD that have been medically discharged. We are particularly interested in the process of adjustment back to civilian life. If you are interested in taking part, please read on.

Explanation: purpose of and background to the research:

You are invited to take part in a piece of research that is being undertaken as part of a Doctorate in Clinical Psychology. There is evidence that individuals in the armed forces are more likely to suffer from post-traumatic stress disorder (PTSD). PTSD is thought to develop after exposure to a terrifying ordeal in which grave physical harm occurred or was threatened. Someone experiencing PTSD may experience flashbacks or nightmares of the event, they may avoid certain activities or places, and may find it difficult to relax. They may also lose interest in activities that they have previously found enjoyable, and may feel alone. Some people may experience some of these symptoms but not receive a formal diagnosis.

This study is interested in the experiences of those military veterans that have had to cut short their military career due to medical discharge.

Please feel free to contact the Researcher or Research Supervisors to ask further questions. Contact details are provided at the end of this sheet.

Do I have to take part?

No, you do not have to take part. It is completely up to you whether you want to take part in this study. It will not affect the support you receive from Combat Stress.

What would taking part involve?

You would need to complete and sign the informed consent form in this pack, and keep the attached paper with your code on. Please keep this paper as it contains details on what to do if you wish to later withdraw from the study.

A suitable time would then be arranged during your residential stay at Combat Stress for the researcher to come and speak with you. Each interview would last no longer than 90 minutes, and would be audio-recorded. The audio-recording would then be written up, and the information that you provided would remain anonymous.

What are the possible benefits of taking part?

There may not be any direct benefits to you. However, it is hoped that this research will help to develop a better understanding of post-traumatic stress disorder and adjustment to civilian life following a medical discharge. This may help improve services for those people that are affected.

What are the possible disadvantages and risks of taking part?

It is possible that talking about your experiences may upset you by bringing back some memories of difficult things which have happened in the past. If this is the case, you may want to talk to friends or family, and to seek support from Combat Stress. If you do not feel able to do this, you may want to talk to the Samaritans (08457 90 90 90) or to your G.P., or to the Forcesline (0800 7314880).

Further information:

If you do decide to take part in the study you will remain anonymous when the study is written up. The informed consent forms and written interview data will be kept in locked boxes for 5 years in keeping with University guidelines, but will be destroyed after this time.

If you complete an interview you can still withdraw from the study without giving a reason up until the point at which the data is analysed and the final draft is written. You can withdraw by sending the Researcher an email or contacting Charlotte Johnson at Combat Stress.

The research is supervised by Professor Helen Dent, and by Dr Charlotte Johnson (Clinical Psychologist, Combat Stress). In order to ensure the quality of the research they will have access to your data but your anonymity will be protected. External examiners may also have access to your anonymised data for the purposes of audit and governance.

The research will be submitted to Staffordshire University as part of the requirements of a doctorate. In the final write up it will not be possible to identify any individuals. If you would like a summary of the completed project, you can email the Researcher or contact Dr Charlotte Johnson. It is hoped that the research will be published in an academic journal and findings may be presented to interested professionals.

If you have further questions about the research please feel free to contact the Researcher or Research Supervisors. The Researcher can be emailed at xxxxxxxxx@student.staffs.ac.uk. Research Supervisor Dr Charlotte Johnson can be contacted at Dr xxxxxxxxx@combatstress.org.uk and Professor Helen Dent can be contacted at xxxxxxxxx@staffs.ac.uk If you do not have access to email, you can leave a message for Charlotte, Helen or the Researcher at Combat Stress, Audley Court.

Thank you for taking the time to read this information sheet.

Rebecca Lovatt

Trainee Clinical Psychologist

Appendix L: Informed Consent Form

STAFFORDSHIRE UNIVERSITY

RESEARCH INFORMED CONSENT FORM

Title of Project:	From civilian to military life, and back again: The experiences of veterans with PTSD leaving the British Armed Forces via medical discharge	**Ethics Approval Number:**	X
Investigator(s):	Rebecca Lovatt & Dr Charlotte Johnson	**Researcher Email:**	X

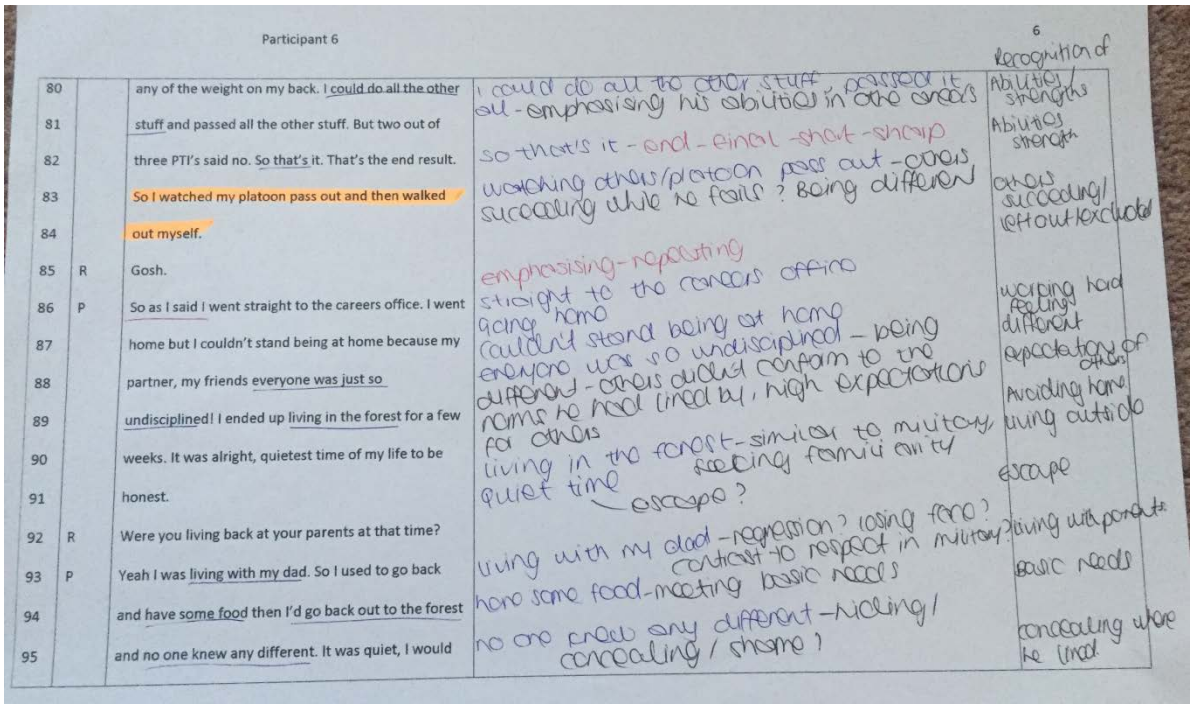
Please read the following statements and, if you agree, initial the corresponding box to confirm agreement:

	Initials
I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw up until the analysis stage (date TBC before data collection stage), without giving any reason.	
I understand that my data will be treated confidentially and any publication resulting from this work will report only data that does **not** identify me. I understand that my data will be kept for 5 years and then destroyed.	
I freely agree to participate in this study.	

Name of participant (block capitals)	Date	Signature
Researcher (block capitals)	Date	Signature

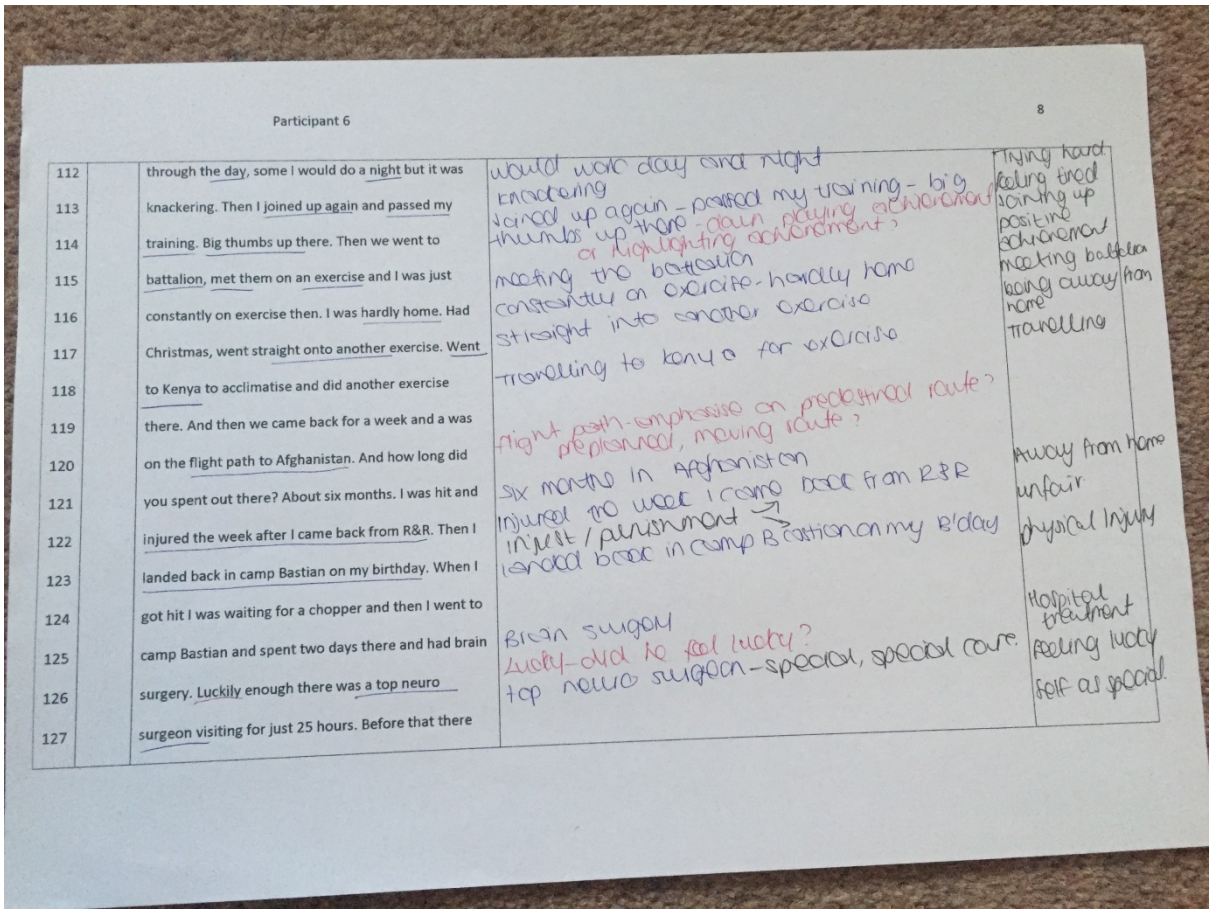
If you would like a copy of this consent form to keep, please ask the researcher. If you have any complaints or concerns about this research, you can direct these to Dr Charlotte Johnson (Senior Clinical Psychologist, Combat Stress)

Appendix M – Example of line by line coding (participant six)



Participant 6

80		any of the weight on my back. I could do all the other	I could do all the other stuff, passed it all - emphasising his abilities in one areas	Recognition of Ability/ strengths
81		stuff and passed all the other stuff. But two out of		Abilities strength
82		three PTI's said no. So that's it. That's the end result.	so that's it - end - final - short - sharp	
83		So I watched my platoon pass out and then walked	watching others/platoon pass out - others succeeding while he fails? Being different	others succeeding/ left out/excluded
84		out myself.		
85	R	Gosh.	emphasising - repeating	
86	P	So as I said I went straight to the careers office. I went	straight to the careers office going home	working hard feeling different
87		home but I couldn't stand being at home because my	couldn't stand being at home everyone was so undisciplined - being different - others didn't conform to the norms he had lived by, high expectations for others	expectations of others
88		partner, my friends everyone was just so		Avoiding home living outside
89		undisciplined! I ended up living in the forest for a few	living in the forest - similar to military, quiet time, feeling familiarity	
90		weeks. It was alright, quietest time of my life to be	escape?	escape
91		honest.		
92	R	Were you living back at your parents at that time?	living with my dad - regression? losing face? contrast to respect in military	living with parents
93	P	Yeah I was living with my dad. So I used to go back	have some food - meeting basic needs	basic needs
94		and have some food then I'd go back out to the forest		
95		and no one knew any different. It was quiet, I would	no one knew any different - hiding/ concealing / shame?	concealing who he lived



Participant 6

112		through the day, some I would do a night but it was	would work day and night	Trying hard feeling tired
113		knackering. Then I joined up again and passed my	knackering	Joining up
114		training. Big thumbs up there. Then we went to	joined up again - passed my training - big thumbs up there - down playing achievement or highlighting achievement?	positive achievement
115		battalion, met them on an exercise and I was just	meeting the battalion	meeting battalion
116		constantly on exercise then. I was hardly home. Had	constantly on exercise - hardly home	being away from home
117		Christmas, went straight onto another exercise. Went	straight into another exercise	Travelling
118		to Kenya to acclimatise and did another exercise	travelling to Kenya for exercise	
119		there. And then we came back for a week and a was	flight path - emphasise on predestined route? predestined, moving route?	
120		on the flight path to Afghanistan. And how long did	six months in Afghanistan	Away from home
121		you spent out there? About six months. I was hit and	injured the week I came back from R&R	unfair
122		injured the week after I came back from R&R. Then I	injust / punishment → landed back in camp Bastion on my B'day	physical injury
123		landed back in camp Bastian on my birthday. When I		
124		got hit I was waiting for a chopper and then I went to	Brain surgeon	Hospital treatment
125		camp Bastian and spent two days there and had brain	Lucky - did he feel lucky?	Feeling lucky
126		surgery. Luckily enough there was a top neuro	top neuro surgeon - special, special care.	Self as special
127		surgeon visiting for just 25 hours. Before that there		

Appendix N – Example of emergent themes in chronological order (participant six)

PX6	Feeling excluded	Line 39
PX6	Acting quickly- self	Line 40
PX6	Trying hard/attempts to better self	Line 41
PX6	Sustaining physical injury	Line 43
PX6	Financial difficulties	Line 50
PX6	Loss of old self	Line 57
PX6	Importance of self-image	Line 58
PX6	Sexual promiscuity / sexual urges	Line 60
PX6	Life goals/loss of expected self	Line 62
PX6	Family expectations	Line 66
PX6	Relationship breakdown	Line 70
PX6	Joining up	Line 74
PX6	Trying hard/attempts to better self	Line 76
PX6	Sustaining physical injury	Line 78
PX6	Pride	Line 79
PX6	Recognition of strengths	Line 81
PX6	Success of others	Line 83
PX6	Acting quickly- self	Line 86
PX6	Expectations of others not met	Line 89
PX6	Avoiding home	Line 89
PX6	Living outside	Line 89
PX6	Escape/avoidance	Line 90
PX6	Living with parents	Line 93
PX6	Meeting basic needs	Line 94
PX6	Concealing from others	Line 95
PX6	Moving around	Line 97
PX6	Poor memory	Line 98
PX6	Trying hard/attempts to better self	Line 102
PX6	Starting new relationship	Line 104
PX6	Explaining self and behaviour	Line 105

PX6	Acting quickly- self	Line 108
PX6	Life goals	Line 109
PX6	Importance of being in employment	Line 111
PX6	Trying hard	Line 112
PX6	Becoming fatigued	Line 113
PX6	Positive achievement	Line 114
PX6	Meeting battalion	Line 115
PX6	Being away from home	Line 116
PX6	Travelling with the military	Line 118
PX6	Being away from home	Line 121
PX6	Experiences as unjust/unfair	Line 122
PX6	Physical injury	Line 124
PX6	Hospital treatment	Line 125
PX6	Appraising situation as lucky	Line 126
PX6	Self as special	Line 127
PX6	Feeling lucky	Line 129
PX6	Close to death	Line 130
PX6	Specialist brain injury service	Line 131
PX6	Specialist military service	Line 133
PX6	Making mistakes/regret/hindsight	Line 136
PX6	Being different	Line 138
PX6	Self as special/unique	Line 143
PX6	Professionals did not have the skills to help	Lines 144
PX6	Treated like a prisoner	Line 146
PX6	Lacking control/others have control and power	Line 147
PX6	Being interrogated	Line 148
PX6	Being asked lots of questions	Line 150
PX6	Others made my decisions for me	Line 151
PX6	Safety of other people – from me	Line 152
PX6	Brain injury	Line 154
PX6	Primitive behaviour	Line 155

PX6	Urges to fight or have sex	Line156
PX6	Shame related to sexual urges	Line 156
PX6	Difficult time	Line 157
PX6	Comparing self favourably to others	Line 159
PX6	Others are unsafe/feeling unsafe	Line 159
PX6	Arguing with others	Line 160
PX6	Others causing trouble/drama	Line 162
PX6	More trouble than it was worth	Line 165
PX6	Bad decisions	Line 167
PX6	Relationship breakdown – partner cheating	Line 167
PX6	Feeling vulnerable	Line 169
PX6	Loss of old self	Line 169
PX6	Impact on significant other	Line 173
PX6	Feeling pushed away	Line 176
PX6	Others inciting violence	Line 177
PX6	Living by morals	Line 178
PX6	Walking away	Line 178
PX6	Specialist civilian brain injury unit	Line 180
PX6	Changing hospital/service	Line 183
PX6	Wanting to be closer to home	Line 183
PX6	Making sacrifices for others	Line 187
PX6	Giving voice to my story	Line 195
PX6	Slow progress	Line 196
PX6	Critical of the NHS	Line 197
PX6	Progress- quick-speed	Line 199
PX6	Extent of physical injury	Line 200-204
PX6	Regression to childlike state/dependence on others for care	Line 205
PX6	Relearning the basics	Line 206
PX6	Lots of professionals within the service	Line 208
PX6	My needs were too complex for the service/self as special	Line 210

PX6	Skills of the service	Line 211
PX6	Experience of good care	Line 212
PX6	Importance of shared experiences	Line 215
PX6	Collective loss	Line 216
PX6	Humour and banter as coping strategies	Line 218-222
PX6	Overcoming obstacles	Line 222
PX6	Group (military) identity	Line 222-223
PX6	Determination	Line 223
PX6	Professional help	Line 224
PX6	Despair	Line 226
PX6	Feeling different	Line 227
PX6	Identifying with special/different others	Line 228
PX6	Wrong decisions	Line 231
PX6	Critical of self	Line 223
PX6	Importance of gut feelings	Line 224
PX6	Relationship breakdown – wife	Line 237
PX6	Experiencing others as controlling	Line 237
PX6	Impact of physical injuries	Line 239
PX6	Living with others/family	Line 240
PX6	Getting a pet for company	Line 241
PX6	Seeking education	Line 243
PX6	Loss of future/expected self	Line 244-245
PX6	Changing jobs frequently	Line 247
PX6	Difficult relationship with father	Line 250
PX6	Viewing others as critical	Line 253
PX6	Others don’t understand me	Line 254
PX6	Regression to child state	Line 255
PX6	Leaving the military	Line 257
PX6	Lack of control	Line 258
PX6	Loss of future self	Line 260
PX6	Feeling ambivalent	Line 261
PX6	Making mistakes	Line 263

PX6	Looking after others	Line 264
PX6	Lack of control	Line 265
PX6	Positive support from others	Line 266
PX6	Receiving practical support	Line 270
PX6	Under scrutiny	Line 275, Line 317
PX6	Memory difficulties	Line 277
PX6	Making things official	Line 279, 286
PX6	Withdrawal of support (army based)	Line 281
PX6	Rejection	Line 282, 286
PX6	Acting quickly with speed – self	Line 287
PX6	Seeking support for employment	Line 289
PX6	Expectations of others not met	Line 290
PX6	Experiencing others as passive/not supportive	Line 292
PX6	Role of age/transition/life cycle	Line 296
PX6	Lacking choice/control	Line 297
PX6	Being different from other veterans	Line 300
PX6	Taking action	Line 302
PX6	Wanting to talk about difficult experiences with others	Line 302
PX6	Feeling left out/excluded	Line 303
PX6	Having nothing left/depression	Line 304
PX6	Attempts to seek support	Line 308
PX6	Seeking benefits/financial support	Line 310
PX6	Hidden difficulties (mental health)	Line 313
PX6	Others minimising difficulties	Line 315
PX6	Feeling rejected	Line 316
PX6	Unworthy of time/being made to wait	Line 318
PX6	Dismissed	Line 319
PX6	Feeling alone	Line 320
PX6	Left to fight my own battle	Line 321-322
PX6	Wasting time	Line 323

PX6	Takes too long	Line 323
PX6	Under scrutiny	Line 325
PX6	Financial difficulties	Line 328
PX6	Time period – first few months	Line 328
PX6	Having nothing	Line 329-330
PX6	Feeling important – people wanting to listen	Line 333
PX6	Having morals	Line 334
PX6	Blame	Line 335
PX6	Getting paid	Line 336
PX6	Basic needs not being met	Line 339
PX6	Drastic-severe	Line 340
PX6	Blame	Line 343
PX6	Mental health difficulties	Line 344
PX6	Mental health symptoms	Line 345, line 352
PX6	From the beginning	Line 348
PX6	Relief from diagnosis	Line 349
PX6	Anxiety symptoms	Line 353
PX6	Being deprived	Line 355
PX6	Increased awareness of Mental Health from treatment	Line 360
PX6	Reaching out, presenting at Mental Health services	Line 363
PX6	Positive experience of seeking support	Line 366
PX6	Showing emotion/emotional response	Line 368
PX6	Feeling that others minimise my problems	Line 371
PX6	Escalation of difficulties	Line 373
PX6	Rejection	Line 375
PX6	Taking time off work – sick – mental health	Line 375
PX6	Feeling stuck	Line 378
PX6	Lack of treatment for Mental Health	Line 379
PX6	Blame	Line 381
PX6	Managing Mental Health symptoms	Line 385

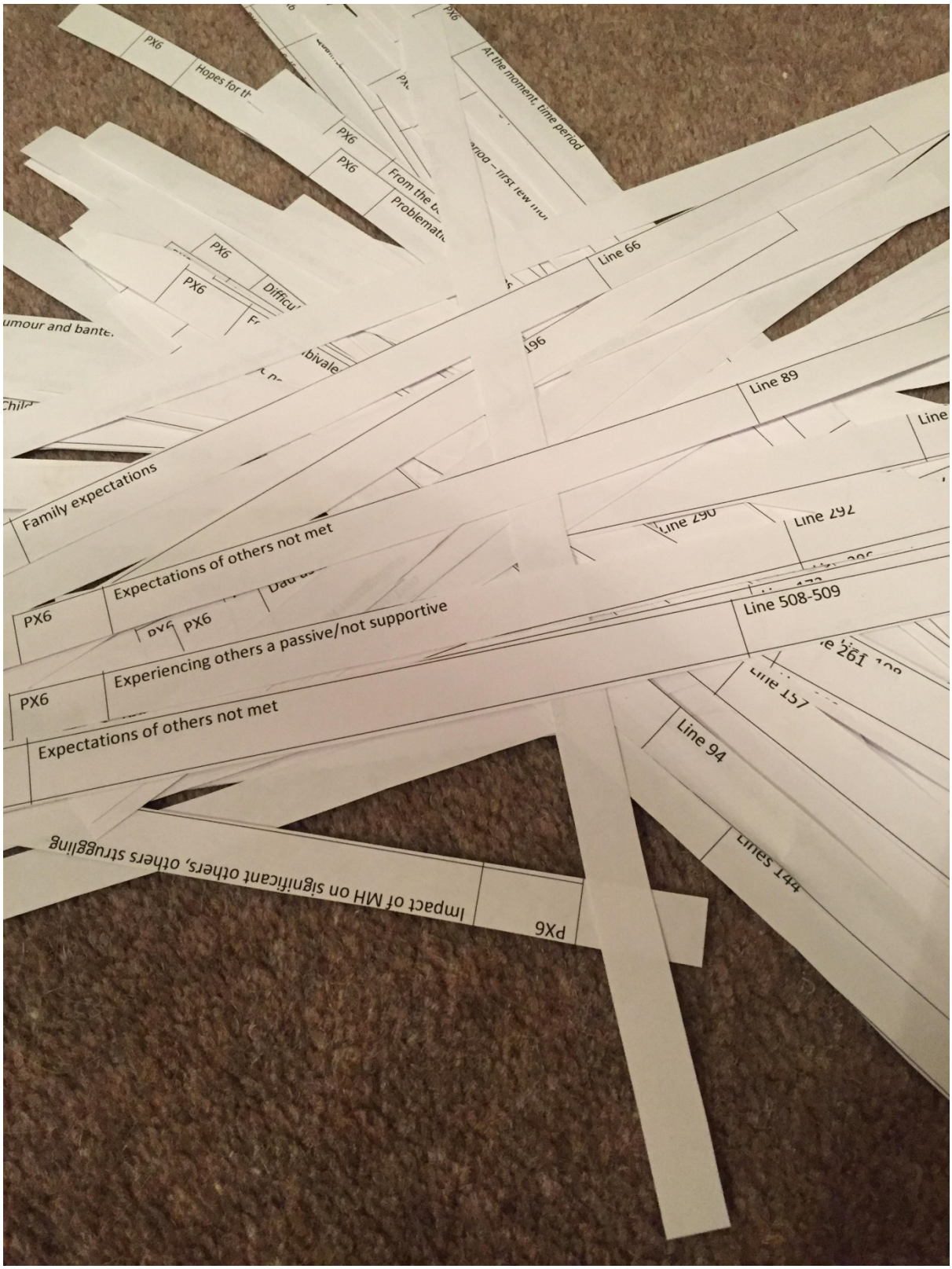
PX6	Symptoms as positive – escape from reality – familiarity	Line 387
PX6	Mental Health symptoms	Line 390
PX6	Responsibility	Line 391
PX6	Caring for others/looking after others	Line 391
PX6	Mental Health symptoms	Line 396
PX6	Concealing Mental Health symptoms from others	Line 397
PX6	Anxiety as a thing that woman experience/Gender differences	Line 400
PX6	Losing contact with people/loss of social relationships	Line 406
PX6	Feeling stuck while others move on	Line 408
PX6	Avoiding social contact	Line 409
PX6	Rejection	Line 412
PX6	Loss of future self	Line 412
PX6	Having nothing – despair	Line 415
PX6	Financial difficulties	Line 415
PX6	Loss of future self	Line 416
PX6	Relationship breakdown	Line 417
PX6	Coping with aggression – others inciting violence	Line 420
PX6	Being pushed away, rejected	Line 420
PX6	Impact of Mental Health on significant others, others struggling	Line 423
PX6	Importance of attributing blame	Line 427
PX6	Rules for living/morals/standards	Line 428
PX6	Gender differences	Line 429
PX6	Being victimised	Line 431
PX6	Others showing emotion, impact on significant other	Line 432
PX6	Losing control	Line 433
PX6	Escaping/avoiding	Line 434

PX6	Physical violence	Line 435
PX6	Difficult relationships, strain on marriage	Line 435
PX6	Friendship	Line 442
PX6	Valuing special other	Line 443
PX6	Lacking friends, social support	Line 447
PX6	Downhill trajectory	Line 448
PX6	People taking advantage	Line 452
PX6	Old self	Line 452
PX6	Old self as passive	Line 453
PX6	Time periods	Line 457
PX6	Lacking tolerance for others	Line 460
PX6	Nowhere to escape to, feeling trapped	Line 462
PX6	Not wanting to burden others	Line 463
PX6	Lacking support	Line 464
PX6	Justifying difficulties	Line 465
PX6	Rejection	Line 468 , 504
PX6	Negatively comparing self to others	Line 475
PX6	Negative cognitions, hopeless	Line 476
PX6	Deserving of recognition	Line 477
PX6	Six months, time period	Line 483
PX6	Feeling bitter	Line 484
PX6	Pension, financial difficulties	Line 484
PX6	Deserving of recognition	Line 487
PX6	Blame	Line 490, 498
PX6	Housing difficulties	Line 499
PX6	Justifying opinions	Line 501
PX6	Finality	Line 503
PX6	Emotional response/reaction/feeling	Line 504
PX6	Expectations of others not met	Line 508-509
PX6	Mental Health	Line 510
PX6	Blame	Line 513
PX6	Hopes for the future	Line 516

PX6	Trying hard, wanting to better self	Line 518
PX6	Qualifications	Line 519
PX6	Self as important/special	Line 525
PX6	Difficulties obtaining employment	Line 526
PX6	Being let down	Line 527
PX6	At the moment, time period	Line 528
PX6	Depressed thinking	Line 529
PX6	Children as a protective factor	Line 531
PX6	Pride	Line 535-537
PX6	Family scripts	Line 539-540
PX6	Dad as main care giver	Line 540
PX6	Morals/rules for living – importance of providing for children	Line 548
PX6	Failure	Line 553
PX6	Employment obstacles	Line 555
PX6	Mental Health impacting on employment	Line 556
PX6	Escaping/avoid	Line 557
PX6	Improving self – qualifications	Line 558
PX6	Self as successful	Line 560, 563
PX6	Helping others, saving lives- employment	Line 567
PX6	Gender differences	Line 569
PX6	Blame	Line 571
PX6	Others as judging, critical	Line 576
PX6	Rejection	Line 586
PX6	Failure	Line 589
PX6	Not striving, failure	Line 591
PX6	Self as successful	Line 594
PX6	Loss of future self	Line 598
PX6	Depressed hopeless cognitions	Line 600
PX6	Loss of job	Line 601
PX6	Caring for animals	Line 602
PX6	Looking after buildings	Line 606

PX6	Problematic relationships	Line 607
PX6	Loss of future self, negative impact on pride	Line 609-611
PX6	Rejection	Line 611
PX6	Low morale	Line 612
PX6	Lack of PTSD treatment	Line 619
PX6	Critical of self	Line 619
PX6	Making mistakes	Line 620
PX6	Squaddie to civvy-identity shift	Line 623
PX6	No time for adjustment	Line 624
PX6	Squaddie identity	Line 627
PX6	Problems not severe enough	Line 631
PX6	Negative thinking	Line 632
PX6	Diagnosis as positive	Line 634
PX6	Positive experience of help	Line 635-639

Appendix O – Example of emergent themes (participant six)



Appendix P – Emergent themes across participants

Appendix Q – Example table of master themes (participant six)

Theme	Line
Loss	
Life goals/future self	62,109,244,416
Independence	93,205, 240, 255
Old self	43,57
Financial difficulties	50, 415
Relationship difficulties	70, 167, 237, 417
Employment	375, 555, 601
Support	281
Feeling stuck	408, 378
Pride	535
Memory	98
Coping – fight or flight	
Urges to have sex	60,156
Primitive behaviour	155
Escaping/avoiding	89,90,434,557
Avoiding social contact	178, 409
Physical violence	177,435
Sense making	
Justifying difficulties	465
Failure	553,589
Experiences as unjust	122
Rules for living	334,428
Self as special	127, 143, 159,228
Appraising self as lucky	126
Blame/mistake making	167,263,343,490, 571
Attempts to better self	102, 112,114,518
Humour	218
Being different	
Under scrutiny	150,325,146, 105

People taking advantage	452
Others as critical/controlling	253,237, 265
Feeling vulnerable	169
Pushed away/rejected	39, 300,420, 468,504
Being victimised	431
Concealing things	95
Defining moments	
Joining up	74
Meeting the battalion	115
Finality of leaving	257, 286, 503
Reaching out	
Seeking education	243, 558
Seeking employment	111,289
Support from others	266,308,442
Shared experiences	215, 302
Looking after others	264
Mental health	
Symptoms	352,385, 396
Diagnosis as positive	634
Increased awareness	360
Lack of treatment	379, 619
Hiding difficulties	313

Appendix R – Supplementary evidence for themes

Identity	Participant	
Becoming part of the outgroup: "being a second class citizen"	Billy	L623-628 "I've gone from squaddie life to civvie life in a flash and I've had no time, well I had no adjustment"
	Dale	L107-112 "You see when you leave you are given 6 months mental health support from the army, so it's like provided by them. It was on the army barracks and I didn't wanna associate with it. I thought like I'm out now, I don't want anything to do with you." L210-211 "Everyone was saying I was different, I'm weird, I wasn't the same so I went all reserved and kept myself to myself"
	Eric	L236 "I'm ex-military, I wouldn't call myself a civilian. I've served."
	James	L215-216 "Oh yeah, that's the only way you could feel. You are now a second class citizen." L218-221 "Well I was a1 before, and now im not a1 anymore, im not good enough anymore. So that was it. Of course I couldn't get a job you know – I was almost unemployable. I couldn't even get a job in security as they said I was too violent."
	Charlie	L170-172 "I said I need help here because I'm becoming ill. I went to the council and they said we can't help you because you're still military. I'm like will someone tell me here am I military or a civvy? L236-241 "Well its hard to say really. I'm in limbo between the two. I still feel military and I almost feel civilian too. But im trying to make a compromise between the two. Im trying to get things still from the army which I can't get hold of because the civilians side of it wont allow me to do it. So im still like trying to do my sources and my resettlement but ive not done anything."

	Andy	L116-118 “All of my friends are army, I’ve hardly got any civilian friends. I don’t have time for civilians; they aren’t on the same wave length as me.” L120-124 “Well the way they work. In the army we get the job done where as they are a bit slap dash. I think it’s the way you’ve been trained. You’ve been trained in controlled aggression whereas civilians are not and they get upset. They have no format. Civilians, you talk to them and you have to be one step ahead of them, theyre different.”
	Tom	L115-116 “It’s a massive culture shock for a lot of people because you get everything done for you.” L326-327 “No no…well i….at that point I couldn’t be dealing with anything that was military, any green kit or anything like that” L468-469 “’cause these are all civvies…they’re just so inept.” L472 “I will always be military me”
The old self versus the new self	Billy	L169-170 “But when I was injured I felt like glass, I didn’t feel like I was going to get anyone again after I got injured.” 450-461 “I think what’s happened is I was a lot more tolerant with people and people being dicks and stuff. People seem to think they can run all over you. I used to get, well I sort of stood my ground but I wouldn’t hit back or have a go or anything like that. If someone in charge told me you’ve got to do this I wouldn’t just stand there and say No id just get on with it and would probably talk to them after. But in the last year it’s like if someone told me to do something and I knew it wasn’t going to work then I would just say, I lost all tolerance with people. Including in my marriage and voluntary work.”

	Dale	L197-204 “Yeah, I’m normally bladdered off two pints now. I have to slowly slowly have a nice quiet pint. I used to go out and get smashed all the time. I can go on a night out sober now, it’s hard like to just like have a couple and that it, but I’m not taking no drugs or nothing so. It’s been hard.” L277-281 “I just like to…because of my arm and stuff I just felt self-conscious and stuff. So I buy a load of clothes. Some people might look at the labels instead of my arm. But I loved designer clothes before I signed up too. It just it made it better.” L368-371 “Before I went I just used to take it for partying but then when I got back from afghan I started using it as a coping strategy.”
	James	L540-544 “I used drugs in the early days, alcohol to excess and on new years I got that smashed that I drank three quarters of a bottle of whiskey. It took me three days to get up and the wife said if I you ever do that to me again im going to leave you. And that was it, I’ve not touched a drop since.” L588-597 “Well in the early days when we first moved to the farm I was a bit of a nutter. But that served its purpose because you’d have kids come round and they would take shots at the horses because it was fun. But you wrap that round their head and you know, I haven’t got a lot of time for speaking about it but I’ve got a bit of a reputation for being a nutter so that suited me. But afterwards, its hard to keep up something like that though. Its very hard to keep that going. But now I cut the grass for the church – I’ve got no grass but ive got a sit on lawn mower just to cut their grass. I am one of the community now, I’m on a few committees you know.”
	Andy	L60-62 “Oh yeah definitely used it for coping. And I started smoking again after Iraq which I shouldn’t have done. I didn’t do it at home though I’d go back to the barracks. I’m not smoking or drinking now though, nothing at all”
	Tom	L196-197 “Yeah it was terrible. See you become all or nothing. I can’t just have two beers. I mean I’m dry” L510-515 “My circle of friends changed because of the army. When I first started you see you had all the lads and stuff like that…civvy lads…I dunno its…what they…I knew

		exactly where they would be at what time. Friday night they would be in the pub in the same seats. That gets boring after a bit for me, its not for me that anymore. Obviously they've stayed the same its me that's changed, its my mentality that's changed." L517-520 "I didn't have the same enjoyment of what they got just through drinking, the conversations weren't the same, proper boring. Yeah. It changed. But then obviously doing courses and moving away and stuff like that you lose them friends anyway…which…It wasn't a problem" L660-661 "Yeah she's very much like me, she er, she's a joker, she doesn't take anything serious. And that's how I used to be"
Putting on a front	Billy	L531-550 "Yeah it's not the best. Well I've got my kid that keeps me going. When he turns round and says "what do you do dad" for work or whatever I want to be able to tell him something. I've done this, I've done my degree, and this is what I do now. I want him to see the progress that I've made so that when he gets older he knows that he can do it. I don't want him to see me living off the dole, even though I refuse to do that. I just don't want him to see that. My dad taught me to cook so that I could do everything. He struggled and we lived a very poor life, not to his fault though. He always had a job but he always got made redundant. We used to have to get stuff from the back of lorries and stuff, it was the only way that we could get stuff. We struggled for our basic needs but I look at him and I think well it wasn't all great but he always made sure he could feed us, he always made sure we were fed first before him and stuff like that. So I've been growing up with that in mind. I want my son to see that too. But he can't see that now as no one will give me a chance."
	Dale	L322-324 "I'm sick of being sat on my arse I hate it. You know earlier when you said are you unemployed I didn't wanna say it." L404-408 "You know what I mean, mums as hard as stone like. She's got to be strong for me hasn't she. I used to have to be strong for her too though so I wouldn't tell her nothing. We were both trying to keep a stiff upper lip for each other."

	Eric	Ln56-62 “We were beaten repeatedly numerous amounts of times. We were mentally ill treated and generally I didn’t learn anything. All I learnt was how to go without food, how to take a beating and I got fit. That’s all I learnt in that year. There was a SRB enquiry but we were too spineless to tell the truth. I think one bloke actually said what happened and the chap got returned to unit.” L63-66 “Worst year of my life. If I had known it was going to be like that I wouldn’t have joined up. But I couldn’t leave because all of my family had been in the forces and I desperately wanted to pass out. So I just had to endure it.” L92-95 “Nothing was mentioned at work, like stress or PTSD, no one knew nothing about it. None of the lads chat about it you just go out and get pissed most of the time.”
	James	L593-596 “Yeah, we tried to…like at the funeral they said before we went they said no tears, there’s cameras there, keep your dignity at all times and this is a good mate, this is a brother here and you know, I think I did cry actually.” L314-315 “They said how’s things? I said well you weren’t bothered at the time when you kicked me out, why are you bothered now? They said well they like to make sure everyone is tickety boo. I said I’ve been having a few nightmares and I’ve been having a few flashbacks, well actually I didn’t use that word at the time it wasn’t a word that I knew about. Their advice was to pull myself together and they said I would be alright.”
	Charlie	L271-277 “Well it got to a point where you had to go to show face. The once you had shown face you left after the CO left, you were allowed to go then. So I used to try and get there as late as I could, get a pint of coke or whatever and keep the coke all night and as soon as I saw the CO going that was my cue to go. I remember passing people on the stairs and they was like where are you going aren’t you meant to be up there in the party? I was like nah I’m going, if he’s going I’m gone.” L309-318 “I started noticing it in other people. When you try to explain to people like “look he’s on the edge” it just falls on deaf ears. They want the people on the ground but they don’t care who they’ve got on the ground if you

		understand what I mean. The more people they have on the ground the more effective it is defeating the enemy. They wanted to get back and get as many people back as they could. Whether you've got a broken foot or whatever they will keep you off the ground, but if it's because you never slept or you're not…you having nightmare it didn't count. It wasn't in their eyes deemed to be serious enough to keep them off the ground."
	Andy	L14-16 "Well you didn't say nothing because you didn't wanna be kicked out. I already had a medical condition so you could never tell anyone that you were actually suffering, you just managed it." L156-158 "Well actually I didn't wanna tell them so I sort of kept it to myself I didn't want anyone to know. Its quite easy in the TA because you have your military life and your civilian life." L161-166 "If they knew I'd have been out on medical discharge straight away as I would have been non deployable so probably no treatment or help or anything. You would have to go through a veteran's agency, the British legion, your GP, and then when it gets really bad you come to Combat Stress. Or…if they medical discharge you I don't know if you would get treatment." L172-177 "But you didn't because you didn't want to have to go see the Psychiatrist and the Medical Office and risk assessments and stuff. You get pulled out of your training and stuff. Like they don't want you having a weapon or anything. Because when you are in the TA you get like a bounty. And they could just stop you from having that while you are being investigated."
	Tom	L166-167 "It's not going to happen to me, you know because you've put on a façade for so long, because you're in charge of the blokes" L223-226 "Never. It was never mentioned, never acknowledged because it was seen as a sign of weakness if you had something like that. So that's when you put on the façade. I know now for a fact looking back and being on here (PTSD programme at combat stress) that everyone….." L235 "Its weakness. You can't show weakness. You can't

		be infallible" L267-270 "Well…it had to say it all…they said that they'd (the army) sent him on early R&R…cause that's what they told everybody…so that was like…that's them there saying he's alright…he needs to go back sort his head out and he'll be back. So that was them denying that there was anything wrong with me"

Disconnection	Participant	
From self	Billy	L57-62 "Well so much has changed. I was fit and health before, physical, muscly and athletic. I was a cockney lad, spoke the lingo, but of a…well I won't say womaniser as I was a family man as well. I was very active, big into physical fitness and that. I thoroughly enjoyed life. I've always wanted to be in the army, I always wanted to be a soldier. Since I was a kid I always used to play like that, building bases and tree houses and that's all I wanted to do. All my grandparents had been in the forces." L200-205 "When I got injured I couldn't speak, I couldn't use my right eye, my hearing went, I couldn't move my legs because of the muscles, my left arm I could only move that to shoulder height. I had problems with my right arm as well. I was not far off having to be fed" L255-256 "There me just being blown up and he's hassling me because I don't have a job. It was a bit like being a kid again, back in your parents place." L413-417 "Going through a job that I thought was going to be my life, as I thought I was going to be in for the full 22, to go from that to nothing. I had no money, no job, being told I've retired and I can't work or nothing. That was it"
	Dale	L40-44 "I couldn't be a soldier no more so I didn't wanna do the job no more, and with my arm injury and stuff my head wasn't in the game. It's still hard to face up to that though. I wanted to do my full 22 like, it was going to be my career." L394-400 "It was hard because I couldn't do anything for myself. My arm was just…stuck to me in like a sling. I couldn't do nothing for myself. So I went from being a young lad who thought he could take on the world

		to….mums got to bath me in the morning, mums got to cut my food up for me, mums got to help me get dressed. It's hard."
	Eric	L123-124 "Yeah I noticed myself but other people really noticed too and that was why I got sent back. I feel really bitter about it all, and feel so angry. But I can't do anything about it." L188-193 "Well I'm hoping to get cured. I want to be normal, being able to hold down a job, care for and show my wife and my son that I love them, not being an anti-social leper. I don't talk. I struggle with concentration as there are so many things going round in my head, I'm generally feeling unhappy, feeling guilty about the things I've done wrong." L137-240 "I've also still got a few physical problems. My knees are really damaged and I wear hearing aids although I can't wear them on my right ear as I keep getting infections. I take a lot of pain relief tablets."
	James	L81-84 "Erm that was different you see, that was kind of exciting really, coming from a nuts and bolts type place to, erm, it was a different world. To be honest I would still be in today if I hadn't lost my eye. It suited me." L108-111 "To be honest it wasn't that bad really, it kind of, erm, you never felt as alive as when you were close to that environment. I felt really alive and you never think it's you, you never think anything will happen to you." L184-186 " I could understand if you had one eye and back in the field but I thought there would be something, I would work somewhere and there would be something to sort of…I had just signed on for nine."
	Charlie	L92-94 "Well I was a bit stunned really, I was like what am I meant to do? I've got nowhere, no house organised, no job organised, I've done no resettlement courses, I was just in limbo." L150-154 "Well I was trying to stay as calm as I could but everything that I was walking into was like a brick wall. It wasn't getting me more and more annoyed and with the flashbacks and with the trouble I had going on in my head. I was walking around the corridors in the Premier Inn because there was nothing to do. I was just trying to calm

		myself down." L256-259 "Er well I was going to retrain as I was a driver by trade and I was going to retrade to something that I didn't have to use my shoulders for as I've got arthritis and it was hard to change gear due to the pain in my joints and my ankles aren't going to last much longer."
	Andy	L103-104 "Yeah I really want to stay in. I would have gone on tours until I was 55 and I was too old. That's what I wanted" L237-241 "It's been horrible, really horrible. Sleepless, started getting irritable at work that has caused to be …well I haven't exactly been fighting but I've threatened to lamp someone and the boss said that its affecting things work wise for me. He said it will either go two ways – I decided to go sick." L255-259 "I do nothing really. I've done some relaxation and a bit of art work at home and I've worked in the garden. But I've done nothing really apart from that. I normally get up late because I've not been sleeping and then I have an afternoon kip. You feel lethargic as you're not sleeping."
	Tom	L56-58 "Yeah I remember just throwing me… throwing me weapon on the ground outside and sitting against a wall. And that was the last time I ever put me uniform on." L397-400 "Yeah…because you've obviously been medically discharged through no fault of your own. But even though you get to a rank and then you know your career path and you know you're going to hit that rank by the time you finish…they don't compensate you for that." L408-412 " That you've got all of these reports saying yeah this man will be, this man be, this man will be. But actually when it comes to the crunch…no we will finish you at that rank there. Well no…that's the rank that I was…So yeah, then you're fighting the system again. It seems like it's a constant battle with 'em."
From others	Billy	L87-89 "I went home but I couldn't stand being at home because my partner, my friends everyone was just so undisciplined." L166-168 "Well when I got discharged from the army I discharged myself from her too. She went nuts in the end

		and started, well I think she felt guilty about what she'd done. Instead of trying to work things and make things up she…well it felt like she was trying to push me away. Trying to get me to hit her but I said I'm not going to turn into that sort of guy and walked off" L459-464"I lost all tolerance with people. Including in my marriage and voluntary work. So friends, marriage and voluntary work all went downhill and I had nowhere to rest. I had no friends to go to because they've all got their own lives and their own problems."
	Dale	L170-175 "Yeah. I was with my ex for about 3 and a half years before we split up last year. We were going on different paths and stuff; she was going to uni and she's a lawyer now. She couldn't come to terms with all that had happened in the army, she didn't want to go near me or nothing. I think it was because I was different, I had changed, I wasn't the guy she fell in love with." L189-194 "I tried to talk to her about what was going on but she just didn't wanna hear it. Well I'm not goina tell you then. That's why I just didn't say anything, I felt like everyone was putting me down so I needed something to lift me up."
	Eric	L188-190 "I want to be normal, being able to hold down a job, care for and show my wife and my son that I love them, not being an anti-social leper. I don't talk. " L101-107 ". No one was really interested. I was married at the time and my sex drive just went downhill and it's gone down ever since really. So it's had a massive impact on my relationship. I know there's been periods of time where she hasn't been very happy because of my anger and depression and boughts of violence, bad language and that sort of thing." L220-221 " Me and my son are okay, it's getting better but it was shocking before"
	James	L156-164 "It was back to the council estate, back to me mother. I wasn't married then, she wasn't living with me then. She was doing a course in Newark in Nottingham, a horse course or something. So that was a bit difficult for the relationship (laughter) but it was alright in the end. Her family were quite well to do so I went down like a turd in a

		swimming pool (laughter). I wasn't the highlight of their idea for their daughter but you can't have everything can you. So Prince Charles was marrying Di at that time and we got married in May 23rd so probably a couple of weeks after my injury." L231-235 "It was strange because like I say I couldn't get a job. It was as if I was tainted meat or something, no one seemed to want me you know. And I never seemed to struggle getting a job before, it was like no one really wanted to, it was as if there was a sign over my head saying unclean or something." L534-538 " And you have to start mixing with the public too. The public are fine when they're happy. But if you start doing them a tree and then the next door neighbour don't like it, they get a bit annoyed. I haven't got a lot of patience with people and that seemed to get worse."
	Charlie	L157-163 "Yeah he was military and was back on leave and he said why don't you come over mine. So I stopped at his to take the burden off paying everyday. Then he put me up for two days while he was on leave and I was waking up in the middle of the night screaming and he said…look I can only do a couple of days as your heads not quite with it. So then I had to go back to the Premier Inn because the council wouldn't help me out because I haven't officially left the army because of the plastic." L225-227 "I didn't keep any of my military friends so I only had one friend who was in the army but he'd left two years before me but he'd left naturally." L366-370 "At the moment they just give you little pamphlets and you can give it to your spouse. It says they may experiences this in the next couple of days. But this just puts your family on egg shells because they don't wanna talk to you because you've just come back from such and such and they don't know how to approach you."
	Andy	L18-19 "Well I sleep in different beds from the Mrs due to the night sweats and the dreams and the flashbacks. You just learn yourself to wake up before a dream but then you couldn't sleep and then it all progressed from that over time." L82-88 "We have been 24 years this year in June. I've

		never hit her. I've gone out and had fights but I've never laid a finger on her or nothing. We've argued and snapped and she's give it back and at times she's hit me but I haven't hit her. She's done it with a frying pan over the head one time, a frying pan, a plate at me, cups at the wall. I've just taken all that in my stride but I've never touched her I've just stormed off out and got in trouble outside. They were definitely flare ups" L277-282 "I just walked off. I don't know why but I just walked off and lived on benches. I dunno why – well its when it gets rough at home or rough I just take my poncho and go and sleep in the park. Cool off and let the missus cool off and they go back. I've not been completely homeless but if I didn't have the wife then I would be on the streets. I think I'd be safer on the streets, I don't know why.
	Tom	L130-131 "Because you're there with, with everybody, then suddenly you're on your own." L286-288 "You can't be rational with people…you have, they call it the thousand yard stare where you're just looking through people." L355-359 "She'd known there was something wrong with me and she kept saying you know…you're not the same person. I used to just brush it off and say yeah it's just stress you know…as you go up the ranks you get more hassle you get more grief..i said nah…yeah she knew but until I admit it…no…nothing was going to change was it" L531-534 " Yeah definitely, that two year period where no one come round, people didn't know where I'd gone, obviously I couldn't go out, I didn't wanna go out because I couldn't go to the shops or anything like that because the big crowds and all things like that. People didn't even know I still lived there."

The Will to Live	Participant	Evidence
Buffering the self	Billy	L141-144 “Well it was the first time they had anyone from active service there, they mainly had people that had brain injuries from getting ran over to getting into a fight. I was the second person from the forces. The first guy had been in the RAF and in a car accident, it was his fault. But I was the first one that had actually seen any action” L524-526 “I tried to go through private investigative firms because im a level six investigator, and a police officer is only trained to level 3, so you can imagine how trained I am. I’ve done all the certificates.” L559-560 “So I went to college. I’ve done some tests while I was there and I passed the most difficult test.” L591-595 “. I went onto UCAS and went for the only course available as there was two weeks left before September. It was applied criminology, joint with forensics. I went there to do that, got in with flying colours.
	James	L344-346 “I had drifted into a bit of that sort of violence anyway. You know like I did door work and a bit of close protection and anything like that, that was a little bit spicy.” L470-473 “Yeah I was a tree surgeon, I developed my own business and have my own farm now. I have a couple of houses that I rent out. Touch wood I’ve been quite successful after [the military], Its not been a problem.” L519-521 “I was going to go to Angola at the time to work on the border with some reporter from the Telegraph they wanted an 8 man brick.”
	Charlie	“I was always one of the first ones in and one of the last ones out. By the time I get back in camp after handing it over then there’s no one left, I pretty much had to drag myself out of the zone with all my kit.”
	Andy	L310-311 “Maybe it’s the soldier in me….they’re frightened.” L349-352 “Then they give me a number to ring. But then I think why am I ringing that? Then they said oh right you’re ex forces so they said I had to ring mind. Then I was ringing mind. Why am I chasing it? Why should I have to

		be sorting my own treatment."
	Tom	L402-403 "You know I was…I was flying….i was going to be a Sergeant Major I was going to be a RSM you know" L474-476 "Because I never left…well….yeah….we all do it because you…I always see myself as better than a civvy because I was military. Especially because I was special forces you see." L478 "I always see myself as better than anyone anyway."
Coping the only way we know how	Billy	L89-91 "I ended up living in the forest for a few weeks. It was alright, quietest time of my life to be honest" L154-157 "When you get a brain injury you soon realise how back to primitive you get so I either wanted to fight every one or, forgive me, shag everyone."
	Dale	L65-71 "Then I used in the Army and started using a lot more when I was injured. I got caught by the Army too. They said I was self-medicating which I was – I wasn't doing it to party I was doing it on my own in my room, trying to stay awake from the nightmares and that. I wasn't going out to the pub or anything, I was doing it on my own in my room." L361-366 "I did like four day binges, ten day binges. The army obviously caught me and said right it's a coping strategy and you need to get off it but they didn't give me any help for it. They just swept it under the carpet and said well we're going to take your pension if we catch you again. That was sort of it. It didn't stop me at all." L106-107 "I didn't want anything to do with the army I just wanted to block it all out"
	Eric	L97 "Yeah I drink heavily, probably to cope"

	James	L329-341 “No, I didn’t know I had a problem. Okay I was a bit anxious, a bit angry. I didn’t realise how bad I was until about 15 years after when I was in Paris at the racing and it erm, there was an argument behind me. As we were watching the horses coming through there was this argument as these two Romanian lad that was arguing with a French lad and two French girls. And you know, my French is limited at best but I said hold on sunshine, leave him alone, get off his back, check it in, okay just leave it. The two brothers sort of looked at me and then they started again. I told them to leave it and that was it then, I just went and flipped and fortunately my mates dragged me off and we disappeared into the crowd. The police came, security from everywhere and that night a good friend of mine turned round and said you’ve got a problem you have.” L466-467 “Yeah by distancing myself it was just a bad dream, just a poor film or something.” L556-560 “For another reason because that time of year, the start of January, that’s when it actually happened [the trauma]. I’ve never been happy with new years, I’ve never been comfortable with it. As I say I hadn’t had a drink until 2 o clock and then I just went beserk. I just wanted to get out of it, out of the feelings.”
	Charlie	“It was like shunned. If you lost someone you were basically kept occupied so you get through it and then you wouldn’t use any brain power to go back to it because they would have you that far away from the incident and doing various things that you didn’t think about it until afterwards when it was your time to relax and then you reflect back on the incident. And then you carry on the next day even though it meant going back to where the incident was, they just kept you occupied. I noticed the signs in myself towards the end, I wasn’t sleeping, doing 18 hour days and not sleeping and then going back to an 18 hour day. So basically staying awake because you were that hyped up from working all day and all night. You sort of automatically went straight back into it the next day. That went on for about 3 or 4 days and then I collapsed. I physically collapsed, I sat down and then…I

		ended up being asleep for two days." L386-388 "That way its easier to talk about it rather than bottling like I did because you haven't got a clue whats going on"
	Andy	L11-12 "I had a couple of years of night sweats and dreams but you just coped with them" L60-62 "Drinking was definitely used it for coping. And I started smoking again after Iraq which I shouldn't have done. I didn't do it at home though I'd go back to the barracks." L217-218 "It was the lifetstyle, I bet the alcohol contributed to my Heart Attack too. But was all of the stress and they admitted that"
	Tom	L169-172 "You sort all of their problems out but you never deal with your own, and I never dealt with my own problems. You suppress it for so long, and I suppose the mind can only suppress it for so long before it….eventually gives in" L184-187 "I was….i was drinking. But you see the Army is the culture of drinking because that's how they subdue it. So it was just…everyone was doing it…so it wasn't a problem. And you…you don't self-analyse like that when you're in that culture" L239-240 "You have to…its weird. You cant be infallible. You've got to be like a machine. You've got to be cold you've got to be clinical."
Meaning Making	Billy	L126-129 "Luckily enough there was a top neuro surgeon visiting for just 25 hours. Before that there was no one else that could have helped me with the surgery I had. I was lucky that he was there." L520-523 "I've managed to do college which I couldn't even do before. I've done Uni but jobs won't take me on because of my medical. The police won't take me on because of my handwriting."

	Dale	L290-295 “I was unlucky to get injured but lucky to survive and be here. 2mm off my jugular, if it had hit that I’d be dead. That’s how I have to think about it really. That’s what I thought with the drugs as well to make me stop that, I’ve got a second chance.” L437-438 “But they said I would never do half of the stuff that I’ve been able to do”
	Eric	L110-112 “Well I was violent to my son a couple of times and violent to my wife a couple of times which I’m ashamed of. But that’s how I was taught in the Army with violence. All that mental bullying.”
	James	L140-142 “The [hospital name] is meant to be one of the best eye hospitals in the country at the time so I was quite lucky.” L483-484 “Everything is hunky dory, I aint no one’s victim.” L486-488 “Well you listen to the story and you think that’s this that and the other but I aint no one’s victim, I’ve never let me self be a victim by anybody.” L490-492 “I think that they can treat you like that when they hear the story and they’re like, poor you. There’s no poor me. I make my own destiny in life, hopefully! Even though it goes wrong sometimes.” L602-608 “So I think I will always be a veteran but I want people to come to me and ask me about it. I say to them its not a game – you have to remember that for all the years of fun and laughter on the beaches on some warm distant land….it doesn’t really work like that. This is the british army. If there isn’t a war to fight they will find one. Some have listened and some haven’t. Its not the worst life I’ve ever had. The people are alright it’s the actual mechanism that’s wrong.”
	Andy	L108-111 “Well that’s probably what’s kicked it all off[PTSD]. When I was medically discharged I think it was the final nail in the coffin. It made me vulnerable and then it just took over. Yeah that’s it, it made you vulnerable. It kicked in and I was unable to deal with it.”
	Tom	L95-96 “. I mean I was probably quite fortunate because …. My wife didn’t live with me” L366-368 “Yeah..she’s a teacher so she’s got her own

		problems…her own stresses…and then added with mine…its been hard for her definitely. Its.. (pause) I'd say its made us stronger." L596-599 "If I cast aside the last..from when I was ill…and everything before… I had a great time. It was a good life. I went some fantastic places you know, ive been places all over the world where I would never envisage going. So in that sense it was good yeah."
Humour as a shield	Billy	L215-223 "It didn't matter if you'd lost your eye, half your head, your limbs, you always had that banter and I used to walk into a room and I was being wrestled by someone who had no arms or legs. He just jumped over this table and all you see is this stumpy man moving towards you and jumping on you and it just makes you think! He's a cage fighter now!"
	Dale	L430-431 "Well they didn't tell me they told my mum and she got arrested [laughter]" L433 "Yeah she started fighting and hitting the doctor" [laughter]
	James	L142-144 "I asked them what time it was and they said "there's a clock up there are you blind!". I said yeah I am! So that was it then. I got off my high horse then!" L160-161 "Her family were quite well to do so I went down like a turd in a swimming pool (laughter)." L613-617 "They could find out what you can do and what you cant do. I could have been a driver for them, I didn't come out with a driving licence even. So I come out with no skills apart from shooting people. There isn't much call for that around [location]!"
	Tom	L186-188 "And you…you don't self-analyse like that when you're in that culture you just …you know its who can be the best drinker (laughter)" L207-208 "Yeah, that's it. You become institutionalised in it. So yeah, im designated driver now (laughter)" L214 "I never got hangovers you know (laughter). I never got one!"

Reaching out for help	Participant	
Rejection by the military: "There's the door cya later!	Billy	L258-260 "I didn't have a choice, they said with the problems I had I couldn't even sit behind a desk." L279-282 "But as soon as I signed that dotted line it was like "cya later" there was no more support from the army whatsoever, they said you're nothing to do with the MOD no more." L285-290 "I think it was part of the MOD but as soon as the dotted line comes up it's like they cut all ties with you straight away. I've tried to get in touch with the battalion but I couldn't get in touch with them. I've tried to speak to them for references, for jobs and everything."
	Dale	L33-35 "Shit, it's been really hard for me, like the transition, it's a lot different. Like everything is different, there's no one there. There's the door see you later." L492-495 "Obviously when you leave…it's just…as soon as I left they just didn't wanna know me at all. I missed about three sessions over maybe two weeks and that was it to them then, I was gone."
	Eric	L127-140 "They sent me back. They didn't give me any care, just sent me back. I went to the doctors and someone at the TA place, I think she gave me a prescription for so many weeks I was under her and I saw this shit head of a psychiatrist at Catterick and he was crap. I did this questionnaire sheet before I went in there, theres things I put in there that were the first times I've mentioned stuff. I went in there he hadn't read it and he only then realised I was an ex-regular after 10/15 minutes of being in there. He was a complete arrogant individual. He didn't mention anything about PTSD. I remember sometime after I wrote to him. I wanted everything removed that I said at that meeting with him, I got a letter back saying I wasn't allowed to take him to court, mention him to the papers or anything he was absolutely embarrassing. So I just didn't bother, I didn't bother continuing." L142-143 "I handed my kit in and that was it. It was really difficult, it's hard to think about it now." L200 "The military could have treated me with a bit more decency."

	James	L174-181 “I turned back up to the regiment and the regiment had moved but they didn’t tell me. All the furniture had gone and then I was told to go to Colchester, some barracks there. So me and the wife went on the train, caught a couple of buses and went there and sat and waited in the waiting room. Very uncomfortable really, the way they treated you. Erm we just sat there waiting to be called in. They checked me over and told me I couldn’t be an Infantry anymore.” L194-196 “They just said that’s it, you’re medically discharged. Thank you and goodnight.” L376-381 “It just really annoyed me. Why leave me in the early days when I struggled, because I was struggling after. Why leave me struggling when they knew? Are they that desperate for a couple of quid. It really left a bad taste about the Army and everything. About society and you know with the whole “you are just a number and all you were was a number”
	Charlie	L351-361 “People need more support because basically you are dumped and left. They don’t care. There needs to be something in place for when they are medically discharged so that they can go to them and they can discuss with them what the steps are that they need to do to before they are actually discharged. Not just discharge them and expect them to crack on. Like you need to be able to go to them and say im leaving on this date and they will have the expertise to say right you need to go and do this part of the resettlement and get this under your belt. Like you need to do this first, and then you need to do that. They should know the order of things and when people are leaving. Instead of just saying “cya later”. L376-379 “Then let him do his resettlement and then you can go from there. Instead of just saying look the gates shut off you go, we don’t want nothing to do with you now. That’s basically what they did to me.”
	Andy	L336 “Not enough is done. They [veterans] are just forgotten.”
	Tom	L419-423 “I think because they put so many stumbling blocks in so that you’ll give up. Because they know that you’re not, a lot of the lads are not in a mental capacity to…unless you’re really stubborn you just think ahhhh I cant

		be bothered because they are waiting for one of two things – you give up or you commit suicide and they don't have to pay you out." L429-431 "You've given them everything. You sign on that line to say you're..you will give your life if you need to. And they wont look after you afterwards. Yeahhh..thats the bitter pill that you've got to swallow." L558-561 "they just don't wanna acknowledge that its there. It needs to be talked about more but I think the army are scared to talk about it more because theres that many people suffering with it." L587 "And then you're just cast aside like a (…like a stray dog…" L589 "Yeah…you've served your purpose now on your way"
"Pushed from pillar to post": Experiences of help seeking post discharge	Billy	L298-306 "So I went to this place and I sat in this church thing, there was veterans from the Falklands, all they did was talk about what they're going to do for their next meal. I just thought im not having this. I wanted to talk about what happened, I wanted to talk about me being left out, being left out by the army and having nothing left. So I just said that isn't for, I wanna get back not go and chat to people about my next meal." L312-319 "He looked me up and down and said well I expected you to be in a wheel chair. As I look at you I can see you are 22 and you can walk and therefore I can't do anything for you and walked off. Later on I had to go for a medical to push for it, with the job centre. I remember waiting for like half an hour, I went in to see the doctor and he said well you are walking and talking "cya later". L628-630 "I've approached so many different people, no help on civvies street. I just don't seem to qualify for anything."
	Dale	L52-55 "Well I got six months mental health support but my head was that fried and I don't drive so I had no way of getting there so I just didn't go. I hit the drugs hard as well so I didn't turn up to anything." Ln112-117 "I got referred to the NHS as well, like the veterans side of it or something? Well they just binned me straight off. They said they would ring me back, I had to keep calling, I got pushed from pillar to post. So in the end I

		just got in touch with this place. I wasn't seen by the NHS. This is the first help I've had in about a year."
	Eric	L182-185 "I tried to get help. I went to see a psychiatrist and she erm said due to some of the stuff that I told her, she asked if I was a homosexual. So I didn't see her again. But theres nothing I can say or do about it now. No one will get sacked."
	James	L348-362 "So I was like hmmm, alright then, okay. I went to the doctors and said, it seems ive got a problem doc. I spoke to him about it and he said oh right, well we will get to a Psychologist. Then after about three weeks I went to this young lady named X, I will never forget it. She said come in, sit down, was there about an hour and told her the story. Told her about the tribunal, although they said it was my fault, I could have lost my eye at any time. Okay so that was it for me. She said so no ones got in touch with you? I said no. Then she said have you ever heard of anything called PTSD. I said nah, whats that all about then? She sat and explained it all. She asked if she could write to the Army. Knock yourself out love, you'll get nowhere but knock yourself out. This was in the mid 90's. Within five weeks an envelope dropped on the carpet. 25 grand in it and a pension. Whats that all about then? I didn't even cash it, I left it in my draw for a month just in case it was a joke." L368-373 "Yeah they knew all the time but until somebody said "hello, I have PTSD". And this woman who I'd known for an hour, she sent 'em a letter, they don't know him from Adam and that really got up nose that did. To think that somebody who has no idea really about it send them a letter after an hour and they said "yeah alright we've know all the time we were just waiting for you to catch up"."
	Charlie	L134-142 "I was like what? I said I'm at my witts end here, I've got nowhere to live. I'm in a Premier Inn at the moment, I've had to pay for a Premier Inn because I had nowhere to go. So then I went to the council and the council couldn't do anything for me. They were going to stick me in some refuge and I was like whats the point of that? I said they must have had a one man flat somewhere to squeeze me in they went "no…nothing on the books." Plus I was down as a single person so were going to stick you in this refuge. So I went

		nah il stay in the premier in! And that's where I stayed for...the first month." L340-348 "Well my doctor understood. She noticed whenever I had an appointment I would sit outside until the very last minute and then come in and go straight in as soon as I've seen my name come up. I would avoid everyone. She said "you don't like people do you, you don't like sitting there". I told her that no, I cant do it. She said that next time I came I could bang on her window at the time of my appointment and she would let me in through the fire exit. That way I could go straight into her office instead of going into where it was packed. I wish people had thought like that."
	Andy	L336-345 "The NHS lets you down and they don't understand. I think its disgusting to go through…..well at first I went to the GP…I took an overdose because my hanging failed and I was absolutely pissed so I took all my codeine and that was first. They took me to A&E and you know you see the psychiatric team well they said go combat stress. And I think that is really sad. Go to your GP and they do nothing. My thoughts of self harming had gone so they discharged me and I felt let down from that when they could have done treatment or let me see someone like a psychiatrist like you do here. But nothing." L356-362 "As soon as they hear you're a soldier that's it, they don't wanna know even though Cameron says we get priority treatment if its linked to military service. Well that is a load of bollocks. I think its all to do with money again. Its going to cost a lot of money to treat a person with PTSD and they know theres a bomb shell out there that's going to happen. And its all going to cost money to treat us all."
"It's about education": Future service provision	Billy	L310-315 "Even though they wasn't ready for what happened to me there was definitely skill there and the equipment. I think there's only another two places like Headley Court. It was really good. Because there was veterans in there, there was people in there that had gone through what you'd been through." L471-477 "Normally people get 2-4 resettlements I think it is, they get a load of cash, they do courses. I've got nothing, no respite. Knowing I've come back from all the action. Most

		lads get like a cool down time.
	Dale	L448-451 “Well most lads get found out that they’re taking drugs and they’re like right that’s it see you later. Whereas I think a lot of lads do it like me, not recreational but like as a coping strategy.” L497-508 “Like the 1-2-1 sessions that you get for 6 months. They should understand that my heads up my arse. Lads that get injured are just missed. I think the lads just need a bit of time and that. They need to know what the signs and symptoms are. I’ve noticed it in a few Army mates, I’ve noticed in them straight away. Because like I’ve learnt about it and now I can notice it in them straight away. Everyone needs to know. You can see lads now going out of massive week benders and you know what they’re doing, you start picking up on the traits. I can spot anyone that’s on drugs but I can tell why now too. Lads just need to know, its education really, it’s a big one.”
	Eric	L208-210 “Well I could have been told about things, just generally educated about it really so you know why some people feel the way that they do. I think it should happen straight after.” L228-230 “It’s been good[combat stress], really relaxing, helpful. They talk to you on a one-to-one most days which is really good. They aren’t good at the time but they are after, it can be hard.”
	James	L612-621 “I think they should have at least kept me in the regiment for six months or something like that doing some menial task. They could find out what you can do and what you cant do. I could have been a driver for them, I didn’t come out with a driving licence even. So I come out with no skills apart from shooting people. There isn’t much call for that around Birmingham! So I think they could have taught you more – took time and just taught me. They could have took time to actually talk to me too, that would have been nice. But they weren’t really interested in talking and that’s why we’re here now. All these years later.”
	Charlie	L227-234 “We both supported each other, he supported me and I helped him. He had a lot of problems with his Mum and she died a few months ago. So I had to help him out and then he let me talk about any grievances I had. He’s due to

		be coming here soon anyway as he has PTSD aswell. I've told him to relax and that he'll enjoy, just getting here and taking as much out of it as he can. Then you can deal with your life and that. I've told him that in the future there wont be as many ups and downs as there is now." L395-408 "You need a separate person to say right this person has got these problems, he's going to do his resettlement at this time, or maybe if needs extend it by a year or two until he's resolved some problems, start the resettlement a little bit later. It would be based on the person. You need someone to do everything with you. Like they would know if you have mental health problems, and they would know what you have to do. They would know who you would need to get in touch with. Or maybe you could do the first bit, have help to calm you down before they give you the rest of the resettlement. But not like leave you and give you a two year gap. You don't wanna put people through more courses when they aren't right in the head. You just need to calm them down first. You don't want people bombarding you with questions because you've still got the battlefield going through your head and someone's trying to talk to you."
	Andy	L384-389 "We have no information before, only when we started going to Afghan and you come to camp decompression and you have PTSD lectures and all that. That's what decompression was. You could see a psychiatric nurse then if you'd already started having problems where as when I was injured in Iraq I was aeromeded straight out and back to [hospital name]. I never had any of the decompression.
	Tom	L551 "There needs to be more education…" L554-559 "But for families and stuff like that, they need to be educated as well for them..you know to witness the signs that somethings wrong, there should be something for them to go and speak to confidentially because there's just nothing like that you know…its..i dunno..its … I don't know how to explain it…you know how can I put it…they just don't wanna acknowledge that its there." L697-703 "I would say …its about education…education is key…because people have got to realise that it is out there

		and if they do get help early on it can be dealt with, rather than letting it fester. Its key to spot the sign early on. They need more trained professionals within the units to identify these…these…trigger points as such. I think that's…that needs to happen. There needs to be more education for wives and family. They need a sounding block as well. I think that's key."