

# **Exploring members of the UK Armed Forces experience of recovery after treatment for a diagnosis of post-traumatic stress disorder**

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## ABSTRACT

**Background and Aims:** The barriers to accessing mental health services for UK members of the Armed Forces (MAF) and veterans experiencing post-traumatic stress disorder (PTSD), have been well documented (Iversen, Van & Hughes, 2011; Murphy, Hunt, Luzon & Greenburg, 2013). However less is known about their recovery following treatment and this study sought to explore veterans' perspectives on what they felt had aided or impeded their recovery.

**Methodology:** Semi-structured interviews were undertaken with nine male veterans who had recently completed treatment for PTSD at Combat Stress. The interview transcripts were analysed using Interpretive Phenomenological Analysis.

**Results:** Four master themes emerged from this analysis and are discussed within a narrative account: "Relief of receiving a PTSD diagnosis", "From layman's knowledge to the technical ins and outs", "Recovery: A changing relationship with self, the world and others" and "The road to more recovery and less suffering".

**Implications and conclusion:** Most participants reported the concept of recovery felt inappropriate and preferred to consider their life post-treatment as a continual journey of coping with their PTSD. Nearly all participants found their diagnosis of PTSD useful, as it gave them a long sought for answer as to why they had been struggling and offered hope for treatment. All veterans identified meeting other veterans as integral to their coping with their problems, along with psychological techniques they learned to help manage their symptoms. The proactive approach taken by many participants suggests hegemonic masculinities could be a resource for coping even if they may make initially seeking help more challenging. This research echoes other literature by arguing for the complex nature of PTSD in veterans, due to stigma surrounding mental health difficulties within the armed forces and society as well as the identity shifts they have to navigate from MAF to veteran status.

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## CHAPTER 1: INTRODUCTION

### 1.1. Background

Recent statistics suggest rates of post-traumatic stress disorder (PTSD) within the UK armed forces have increased since 2007 (Defence Statistics Health, 2014). This growth in diagnosis rates has coincided with the UK's participation in challenging operations in Iraq and Afghanistan, which have prompted extensive media coverage on the effects of war and trauma on UK troops (e.g. Beale, 2016). In addition the growing profile of charities such as Combat Stress and other government backed schemes have increased awareness of mental health conditions and access to treatment, which may have also prompted an increase in PTSD diagnoses (Murphy, Weijers, Palmer & Busuttil, 2015). The government has simultaneously funded a proliferation of research into the impact of deployment on Members of the Armed Forces (MAF)<sup>1</sup> and veterans<sup>2</sup>. However much of the published research from the UK exploring military mental health has been epidemiological in design (e.g. Iversen et al., 2009) and there is a notable paucity of published qualitative studies.

These large scale studies have offered useful insight into the prevalence of mental health difficulties in MAF (e.g. Fear, Jones, Murphy, et al., 2010). They report rates of PTSD within MAF to be around 4%, with anxiety, depression and other common mental health problem rates to be about 20% (Hotopf, Hull, Fear et al., 2006). In 2010 when data was collected for a second time these statistics were found to be reasonably constant (Fear, et al., 2010).

However, relatively few MAF and veterans who have a diagnosable mental health condition access treatment, with estimates that only 23% receive support from mental health services (Iversen et al., 2010). Reasonably given the large number of MAF and veterans who are not seeking help, much research to date has focused on elucidating the barriers or facilitators to people accessing treatment (e.g. Murphy, Hunt, Luzon & Greenberg, 2013). However little is

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<sup>1</sup> The term "members of the armed forces" (MAF) is used throughout this paper and denotes a male or female from any nationality or service who is still serving (e.g. regulars or reservist, navy, army etc.)

<sup>2</sup> A veteran in the UK is defined as a person who has served at least one day in the UK Armed Forces (Danderker, Iversen, Ross & Wessely, 2006).

known about the experiences of MAF and veterans who do access treatment for PTSD and what their lives are like beyond treatment; do they experience “recovery” and if so, what supports this or makes it more challenging? (Iversen et al., 2009).

Most of the recent published research from the UK has conceptualised PTSD and other common mental health conditions experienced by MAF (e.g. depression or substance abuse) within the medical model. Whilst this provides a shared language for describing distress following a trauma and frameworks for their diagnosis and treatment (Stein, Seedat, Iversen & Wessely, 2007), PTSD as a diagnosis has been criticised for de-politicizing and decontextualizing trauma (e.g. Patel, 2003; Summerfield, 2001). Throughout its history PTSD has been inextricably linked with the military, but it has been queried whether the violent, chronic and frequently interpersonal nature of traumas that many veterans experience in combat is comparable with the one-off events many civilians with the diagnosis may have endured (Hamaoka, Kilgore, Carlton, Benedek & Ursano, 2010).

This research will explore life after treatment for veterans with a diagnosis of PTSD, inquiring about how they make sense of their diagnosis and their perspectives on recovery. Initially literature on trauma and PTSD will be reviewed, before shifting focus to considering the military and its relationship with mental health. Finally the concept of recovery will be critically explored in the context of a PTSD diagnosis.

## **1.2. Literature Review**

An initial literature search was conducted using Embase, PsychInfo, PsychArticles and Ovid MEDLINE, using a range of search terms to indicate military (e.g. armed forces, veteran etc.), PTSD and recovery. These searches yielded 2533 articles, titles and abstracts which the author checked for relevance to recovery from a diagnosis of PTSD in MAF and veterans. A total of 86 papers were then sought out by the author to be read and reviewed, on the basis of being published in English and focusing on recovery from PTSD. Most papers were discarded because they focused on less relevant subjects such as

prevalence rates or vulnerability factors for PTSD. In addition to these papers Google Scholar was searched for articles that cited or were cited by these core articles. The author also searched for further articles and books on Google scholar which were relevant to themes discussed in core articles (such as the impact of military culture and masculinity on well-being and mental health). The literature search focused on articles reporting on PTSD amongst MAF and veterans in the UK, but articles were also sourced detailing experiences of PTSD from MAF in other countries to gain greater understanding of the cultural and historical discourses surrounding PTSD. See Appendix 1 for a more detailed description of search strategies.

### **1.3. Overview of Trauma and PTSD**

#### **1.3.1. Trauma in Context**

Descriptions of humans' reacting with intense distress to extreme events have been traced as far back as ancient Greece and Iraq (Abdul-Hamid & Hacker-Hughes, 2014). Whilst ancient Greeks understood mental and physical illness in terms of a disturbance in the equilibrium of different humours (Jackson, 1986; as cited in Abdul-Hamid & Hacker-Hughes, 2014), over time people have drawn on religious, legal and philosophical frameworks to understand responses to trauma (Stein et al., 2007).

"Trauma" initially stemmed from the Greek "to wound" and today is widely used in reference to experiencing a physical injury or mental distress following a disturbance or event (OED, 2007). Last century it was the First World War which brought the injurious psychological impact of trauma into public and professional consciousness. Men returned from the trenches with "nervous" symptoms, intrusive memories and mood changes and were labelled as suffering from "shell shock" or "combat stress". These diagnoses were initially attributed to a physical cause (Herman, 2001), but psychiatrists gradually began to conceptualise it as a nervous condition akin to a male form of nervous hysteria (Whitworth, 2008) which Freud had previously described (Wilson, Friedman & Lindy, 2012). This association with mental health and a damaged psyche, laid the foundations for beliefs that sufferers must have a defective

moral fibre, or even more damning that they were weak, cowardly and worthy of disdain (Herman, 2001). In the 1970s there was resurgence in interest into the psychological impact of trauma, due to feminist movements and social action undertaken by Vietnam War veterans in the USA (Friedman, 2011). This led to trauma reactions being incorporated into the DSM-III with the diagnosis of PTSD (APA, 1980); and people's experiences of flashbacks, mood changes and a sensation of things not feeling real in the wake of a sudden and traumatic event, most likely be diagnosed as PTSD (Cromby, Reavey & Harper, 2013).

### 1.3.1. The Epidemiology of Trauma and PTSD.

Much of the general population are expected to experience a traumatic event at somepoint in their lives (Keane, Marshall & Taft, 2006). However between 70-80% are expected to recover from their experience, with only a small number going on to meet threshold for a PTSD diagnosis (Zohar, Juven-Wetzler, Myers & Fostick, 2008). Thus it has widely been concluded psychopathology is not inevitable following a traumatic experience (Friedman, 2011).

Research has largely focused on exploring risk and resiliency factors as to why some people are more likely to experience distress following trauma, or patterns in traumatic events which tend to trigger these reactions. Keane et al., (2006) in their PTSD literature review highlighted the following variables which may make some people more vulnerable to this diagnosis than others, such as pre-existing factors (e.g. a previous mental health diagnosis or early life adversity); factors to do with the trauma itself such as its objective "severity" or whether the person blanked out, and post trauma factors such as social support being a protector to distress. This research has developed in tandem with psychological theories seeking to explain the myriad difficulties that can arise following exposure to trauma. Over the last thirty years there has been a proliferation of research into trauma reactions. This has been fuelled by continued military conflicts and Western civilians' increased exposure to terrorism (Zohar, et al., 2008), which led to changes in how it is conceptualised in psychiatry.

### 1.3.2. A Psychiatric Understanding of Trauma



In the most recent edition of the DSM-5 (American Psychiatric Association [APA], 2013), a traumatic event is defined as one where a person is exposed to threatened death or serious injury, or a threat to the physical integrity of the person or others (such as sexual assault). The nature of the exposure may be that the person was directly involved, or that they were indirectly exposed to the event through hearing details about it. Interestingly the criterion that an event must evoke “intense fear, helplessness or horror” in the person has been removed since the previous edition in the DSM-IV (APA, 2000), as it was recognised the huge diversity in people’s emotional response to traumatic events means this not a valid predictor of subsequent distress (Brewin, 2011).

#### *1.3.2.1. Symptoms of PTSD in DSM-5*

Whilst a traumatic experience is the cornerstone of a PTSD diagnosis, the DSM-5 (APA, 2013) also stipulates people must be experiencing the following symptoms of intrusion (e.g. memory flashbacks or nightmares where people relive events as if they are reoccurring in the present); avoidance of trauma related stimuli; negative changes in their cognition (anger or depressive symptoms are often described); and alterations in arousal and reactivity (whereby people may feel unsafe and be extra sensitive to sudden noises). To meet threshold for diagnosis symptoms from these different areas must be present at least three months after an event and be causing significant impairment in their daily lives.

#### 1.3.3. Controversies Surrounding PTSD

##### *1.3.3.1. What is a traumatic event?*

PTSD is one of the most controversial psychiatric diagnoses, which Friedman (2011) attributes largely to the problem of defining what is, or is not, a traumatic event. Events are shaped by their historical and cultural context and what is perceived as horrifying in one time and place, may be considered normal in another.

Critics have also voiced concerns about changes to criteria specifying what constitutes a traumatic event (Brewin, 2011); if the criteria is too broad, then this may appear to trivialise the experiences of those who have lived through

extremely distressing events. However if the nature of events which qualify for a PTSD is made too specific, this may deny people who have the other symptoms from accessing treatment. This debate is further complicated by evidence confirming people may respond to the same event in a myriad of different ways (Brewin, 2011).

PTSD de-contextualises trauma and there are debates surrounding hierarchies of trauma exposure which are unaccounted for within DSM-5. Rape has been argued to be a particularly toxic experience (Friedman, 2011), along with other man-made atrocities and disasters (war, terrorism, road accidents etc.) which have similarly been suggested to lead to more prolonged and difficult recoveries from PTSD than natural disasters (Norris, Friedman & Watson, 2002). In their paper, Hamaoka (2010) argue that after disasters caused by humans there is often a sense it should have been prevented which may increase feelings of guilt or anger and that the world is an unjust place. Manmade traumas may also be complicated by prolonged or recurrent stressors such as torture, abuse or combat exposure.

In the DSM-5 PTSD a traumatic event is framed as a one-off occurrence, but Herman (2001) argues this does not reflect many people's experiences of repeated traumas which have a profoundly detrimental impact on their identity and inter-personal relationships. Herman (2001) argues for a spectrum approach and recognition of "complex PTSD", which did not enter into the DSM-5 (APA, 2013) despite significant research and debate (e.g. Resick, Bovin, Calloway et al., 2012).

#### *1.3.3.2. The validity of PTSD as a distinct diagnosis*

Herman (2001) voices concerns that the absence of a diagnostic category of complex PTSD, means people's interpersonal difficulties that may be usefully understood within the context of trauma tend to be conceptualised as personality disorder. This may not only prevent treatment, but is also a particularly stigmatising diagnosis. Others have debated the validity of PTSD with Summerfield (2001) arguing its symptomology of mood difficulties, anxiety and disrupted sleep has significant overlap with a diagnosis of depression.

Within the DSM-5 (APA, 2013) PTSD has shuffled from residing within anxiety disorders, to a new category called trauma and stress related disorders. PTSD now sits beside acute stress disorder, reactive attachment disorder, adjustment disorders, various trauma and stressor related disorders and disinhibited social engagement disorder. Whilst these diagnoses have presumably been categorised on the basis of including some level of stressful or traumatic experience, trauma has been implicated as a risk factor for other diagnoses such as psychosis (Maercker et al., 2013) and borderline personality disorder (Herman, 2001).

As with many other psychiatric diagnoses, PTSD's validity has also been criticised due to the changes in symptomology over time. It has also been critiqued for its lack of cross cultural validity (e.g. Summerfield, 2001), as the variation in symptoms and expressions of distress across cultures has not been acknowledged and incorporated within diagnostic criteria (APA, 2013). The underlying assumption within psychiatric categories that diagnoses are universal is problematic, given the quantity of cross-cultural literature which has demonstrated diverse ethnocultural responses to trauma (e.g. Marsella, Friedman & Spain, 1996).

#### *1.3.3.3. PTSD de-politicises trauma*

PTSD's history is inherently political. Herman (2001) argues its introduction into the DSM-III (APA, 1980) was a triumph for Vietnam veterans after years of social action. More recently others have argued PTSD being a psychiatric diagnosis creates a smokescreen which obscures the social inequalities, injustices and human rights violations which frequently lead to trauma (Patel, 2003). Patel (2003) and Summerfield (2001) argue that PTSD is an individualized model and that by endorsing it, clinicians are re-enforcing that the individual is to blame for their distress and that is they who must change their thoughts and beliefs, rather than looking to structural or political injustices which may maintain violence and oppression. By focusing on the individual, this shields society from turning its gaze on itself and asking what can be done collectively to prevent violence and abuse (Van Ommeren, Saxena & Saraceno, 2005).

Stein et al. (2007) argues the development of PTSD has set the scene for a dangerous dichotomy within society, whereby survivors of trauma are either positioned as victims with a psychopathology, or heroes who have demonstrated great resilience by clinicians and wider society. Summerfield (2001) expounds this perspective by using an example from the Vietnam war. He argues the introduction of PTSD into the DSM-III (APA, 1980) fulfilled political purposes in America, by drawing attention away from the anti-war movement and debate as to the morality of America's foreign policy, to instead focusing on the psychopathology of individuals. The war was largely unpopular due to reported atrocities against the Vietnamese people. Summerfield (2001) argues PTSD served to publically exonerate veterans from blame for their actions during the war; instead of being positioned as evil "baby-killers", they were framed as victims who deserved public support and access to resources such as disability pensions. Yehuda and McFarlane (1995) take a more sympathetic view arguing PTSD becoming a diagnosis empowered veterans', offering them validation of their difficulties and meaning their rights and needs could no longer be misunderstood or ignored by society.

#### 1.3.4. Psychological Theories Explaining People's Response to Trauma

Various theories have sought to explain the development and maintenance of the psychological sequelae associated with trauma of cognitive, emotional, physiological and interpersonal changes (Herman, 2001). The devastating impact PTSD can have on relationships is well documented, as is the protective influence of social support (Bisson, 2009; Harkness & Zadar, 2012). Outlined below are some of the most influential theories researchers and clinicians have used to explain these changes drawing on neuropsychology, learning theory, information processing models, psychodynamic and attachment theory.

##### 1.3.4.1. *Theory of Shattered Assumptions*

Janoff-Bulman (1992) argued people's "shattered assumptions" underpinned difficulties experienced in PTSD. She stated that beliefs people hold of a positive sense of self and that the world is a safe and/or meaningful place, are "shattered" when they experience a traumatic event. She argued well-being

may be sustained following trauma, if people are able to alter their prior beliefs structures and assimilate their appraisals from the trauma into them. Whilst this theory holds some clinical validity, it has been criticised for failing to account for why people with early experiences of abuse and adversity are more likely to get PTSD, as they are less likely to have a positive sense of self or view the world as a safe place (Brewin, Dalgeleish & Joseph, 1996).

#### *1.3.4.2. Attachment theory*

PTSD can have a devastating impact on relationships, as in the wake of trauma people often experience feelings of isolation and a disconnection from others (Harkness & Zadar, 2012). Herman (2001) connects people's relationships following a trauma, to their early life experiences and attachments to a care giver. She suggests these form a blueprint for people to form and maintain relationships and manage emotions throughout their lives. She argues that traumatic events "shatter the construction of the self that is formed and sustained in relation to others.. they violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis" (Herman, 2001, p51). This process increases people's need for protective attachments, but Herman (2001) argues people are often left stuck in a cycle of wanting intimacy, yet withdrawing from closeness with others due to fears of appearing vulnerable or wanting to protect others from their anger and distress.

#### *1.3.4.3. Cognitive Model of PTSD*

Another prominent model of PTSD originated from classical cognitive theory to explain PTSD's development and maintenance. Ehlers and Clarks' (2000) Cognitive Model posits that distress is underpinned by excessively negative appraisals after the traumatic event, which lead to individuals having a sense of serious and continued threat to self. This is maintained by ineffective strategies the person uses to rid themselves of distressing memories and thoughts associated with the traumatic event.

#### *1.3.4.4. Dual Representation Model*

Brewin et al's (1996) model was developed from neuropsychological research and integrates information processing theories with social cognitive theory. It proposes there are two different types of memory processes, one storing

verbally accessible memory (VAMs) and the other situationally accessible memories (SAMs). They argued these memory processes account for the complex phenomenology of PTSD including re-experiencing symptoms and emotional processing difficulties.

#### *1.3.4.5. Social influences on PTSD*

Bisson (2009) argues various social factors moderate people's response to traumatic events, including community support, feeling of connection to family and friends, a valued role, employment, meaningful leisure activities and having basic needs met of food and accommodation.

Harkness and Zadar (2012) also emphasise the didactic nature of social influences, suggesting individuals' cognitive and emotional difficulties may negatively affect relationships, as memory disturbances might lead to difficulties being present in the moment, whilst numbing and avoidance symptoms may cause difficulties in individuals' capacity to identify, modulate and express their feelings to others. Furthermore being preoccupied with grief or guilt, or a fear of loss and problems with trust, shame and feeling worthless may lead to an appearance of self-absorption or people withdrawing from intimate relationships. In this way Herman (2001) argues trauma survivors may enter into a vicious cycle whereby their emotional distress leads them to seek isolation, which prevents them from engaging in protective social activities and relationships

### **1.4. The British Military**

#### **1.4.1. Military culture**

The British Military is not a singular institution, as it consists of three distinct services of the Army, Navy and Royal Air Force (RAF), who all have their own individual hierarchies, culture and histories. One view of the Army and its soldiers may be of a "tough, hard- working institution that is imbued with adventure and a sense of pride in serving one's country" (Atherton, 2009), which has been embodied by numerous recruitment campaigns with the "be the best" slogan (MoD, 2015). Many quantitative studies acknowledge their findings

are limited as they are unable to generalise them across the military, due to the heterogeneous experiences of MAF depending on role, rank, service (e.g. navy, army etc.), deployment history and contract (e.g. reservists or regular). For example, whilst intuitively one may assume that length of service may correlate with diagnosed PTSD, prevalence rates of PTSD have been found to be highest in reservist personnel (Fear et al., 2010). But as Murphy et al., (2013) conclude, many MAF and veterans with mental health difficulties do not seek treatment, which makes it difficult to accurately estimate the number of MAF and veterans living with mental health difficulties.

Despite initiatives to recruit more women, those from diverse ethnic backgrounds and people who identify as gay and lesbian, some argue the army is still constructed as internally masculine and widely held beliefs that “real” men become soldiers (Woodward & Winter, 2007. p64). Evidence of these claims may be seen by men tending to dominate the higher ranks of the military hierarchy in all three services and that some jobs are still only open to them in the UK; this is despite recent NATO and UK governmental pressures for greater gender equality across roles, which Duncanson and Woodward (2015) argue is largely due to continued conflict in the Middle East and fiscal pressures.

The focus of this review is the study of men’s experience within the military, but broader concepts of gender are referred to in recognition of masculinity being a social practice which heavily influences the armed forces. As Woodward and Winter (2007, p3.) argue, “gender informs what contemporary militaries do, how they operate, how they are structured, how they are managed, how they understand themselves”. Gender is not the only aspect of identity which shapes individuals and groups, and social class, rank and sexuality will also be explored. Whilst the author sought out studies focusing on people from minority groups experience of being in the military, a striking (though sadly unsurprising) finding is that the majority of literature speaks to the experience of white heterosexual men.

#### *1.4.1.1. A new way of life*

Regardless of the service, entering the military entails a whole new way of life for recruits. Bergman, Burdett and Greenberg (2014) explored recruits transition as they gain a new uniform, enter into a strict hierarchy of power requiring

saluting superiors and referring to them with deference, whilst also adapting to a communal lifestyle and the responsibility of being sanctioned to carry and use weapons. Additionally recruits are required to adopt a new language (e.g. acronyms) and embody core values of loyalty, integrity and commitment to duty, as part of their transformation from civilian to warrior. Furthermore this process often occurs when men are at a point of transitioning from adolescence and adulthood, which may have a lasting impact of their identity both as themselves and as a MAF (Bergman et al., 2014).

#### *1.4.1.2. Camaraderie*

Atherton (2009) talks of the close-knit camaraderie that many experience from being in the military as akin to a “brotherhood”. He suggests this brotherhood is likely formed through shared experiences of strenuous basic training and the respect that is gained from fellow recruits and superiors through surviving this initial training course. Basic training is pictured by Atherton (2009) as a brutal dance; recruits often experience a sense of disempowerment from the physical and emotional knocks they experience, but through being sanctioned to act violently are also given power and status. One consistent characteristic of the military is high social cohesion which is carefully mastered as an essential component of the group’s efficiency, success and emotion control (Braswell & Kushner, 2011). Part of this approach is to use humour to both self-deprecate, mock the weaknesses of others and make light of situations as a means to gain respect (Atherton, 2009).

#### *1.4.1.3. Squaddies and civvies*

A complex and uneasy relationship has been reported between the military and civilians. Despite the widespread reverence given to memorial Sunday and support to charities such as “Help for Heroes”, unpopular wars in Afghanistan and Iraq repeatedly make the headlines. Over 450 British service men and women have died in Afghanistan alone (MoD, 2015). A further 20,000 local Afghani people are also thought to have lost their lives (Bartlett, 2015) in a conflict which remains in the headlines with criticisms levied at politicians for the opaqueness of rationale for initially going to war (Jenkins, 2013).



Literature has investigated how MAF and veterans internalise public perceptions of the military institution and specific conflicts. A participant in Atherton's (2009, p 825) study reported "the public only see us as killers, torturers and invaders". Herman (2001) in her work in America described veterans' sensitivity to public opinion. She argued acceptance from civilians as to their role and its morality can help reintegrate them into civilian life, whereas rejection can exacerbate feelings of isolation and their experience being insurmountably different.

Similarly Burnell, Boyce and Hunt (2011) found in their qualitative research that veterans able to morally justify their role in operations, reported more positively about their deployment and societal support than those who were unable to justify their deployment. These findings suggested that how veterans make sense of their experiences may be mediated by their own and others' moral evaluations and the wider socio-political context. Research undertaken in South Africa has also suggested that veteran's internalising social dissatisfaction about conflicts can also increase their likelihood of their experiencing symptoms of PTSD (Emsley, Seedat & Stein, 2003).

#### 1.4.2. Transitioning to Veteran Status

It was recently estimated that about 22,000 people leave the regular armed forces annually (Bergman, et al., 2014) and that there are an estimated 3.8 million veterans currently living in the UK, although this number will decline as time passes since World War Two (Woodhead, Rona, Iversen et al., 2011). Whilst it has been suggested most ex-servicemen cope well with transitioning to veteran status (Iversen & Greenberg, 2009), some of the biggest hurdles veterans' face include loss of status, financial difficulties and family readjustment (Bergman et al., 2014).

It has been suggested that military institutionalisation can cause short term adjustment difficulties when MAF transition to veteran life, as when they were in the military their daily needs of food, accommodation, clothing and welfare were all provided. Bergman, et al., (2014) discuss how for long serving recruits, the military way of life becomes what the individual "is" and not merely what they "do" for work, and the civilian world may feel disorganised and chaotic compared with the military. In their work with Vietnam veterans, Harkness and

Zadar (2012) found many of them commented on the mundane pace of civilian life compared to the unpredictability and excitement of being in the military life. Furthermore they spoke of feeling valued and competent in their military roles and the intense camaraderie, which they missed as a veteran.

Becoming a veteran entails finding new work and taking on different and new responsibilities. Re-employment may be further complicated by mental health difficulties, as Iversen et al., (2005b) concluded veterans who had a mental health problem at the time of their leaving the forces, were likely to still have a mental health problem and be unemployed three years after leaving. Scaturro and Hayman (1992) observed from their work with Vietnam veterans that their energy was often absorbed by suppressing mental health symptoms, rather than being directed towards finding meaningful employment. However the barriers veterans face in finding employment are also been highlighted in Ashcroft's (2012) survey, which exposed pejorative public attitudes to veterans. They surveyed perspective civilian employers about hiring veterans and found that 10% of them said they thought the phrase "aggressive, institutionalised or likely to have problems" best described those leaving the armed forces.

Interestingly no correlation between length of service and difficulties transitioning back into civilian life has been found, as many of those with the greatest difficulties served a relatively short time in the Armed Forces (Bergman, et al., 2014). Yet those who do have difficulties transitioning are thought to be at greater risk of mental health problems (Bergman, et al., 2014). However this affect could be bidirectional, as perhaps some veterans do not share or recognise their distress prior to leaving the forces which might leave them feeling increasingly alienated and rejected as veterans.

#### 1.4.3. Military Masculinity

It has been suggested that most militaries worldwide tend to define soldiers as embodying of traditional male sex role behaviours (Barrett, 1996), including strength and lack of sensitivity to pain and discomfort.

##### 1.4.3.1. *What is it to be "masculine"?*

Ideas of sex and gender are complex. Whilst it has been argued that all known cultures distinguish between the “sex” of males and females on the basis of biological attributes, gender refers to social processes and how people enact being “masculine” or “feminine” (Cromby, et al., 2013). Gender in contemporary culture is being constructed as more fluid than ever, as more people share their stories of not identifying with their biological sex or identifying themselves as a blend or neither sex (Cromby, et al., 2013).

Despite the growing fluidity in how gender is constructed, it has been repeatedly demonstrated that people in Western cultures tend to associate certain characteristics with one gender more than the other, despite repeated evidence that there are no consistent differences between the psychological attributes of men and women (Edley & Wetherell, 1995). For example, Bem (1974) found in her research that aggression and self-reliance were typically associated as “male” traits.

The nature-nurture debate surrounding gender development is a heated one and significant theories include Bandura and Walter’s (1963) social cognitive theory. They suggested children learn to enact “masculine” or “feminine” characteristics through learning what role is preferred and expected of them in their social world. This process of gender socialisation is enabled by observation, modelling and imitation, which is guided and maintained by punishments and rewards. Whilst this theory neatly explains the relationship between the individual and how they “do” gender, it has been criticised by Connell (1995) for failing to address power relations. By talking of “norms” of behaviour, the experience of anyone who does not identify with this “norm” (often people who are not white, heterosexual or middle class) is classed as defective or deviant. Whilst arguably this theory is not sufficient alone to explain gender development universally, it may offer insight into how preferred versions of masculinity are enacted and reproduced in the military such as traits of physical and emotional toughness, stoicism, self-reliance, putting up with hardship and being “action-oriented” (Higate, 2003).

#### *1.4.3.2. Hegemonic Masculinity*

Connell (1995) described society's dominant and preferred notions of masculinity as "Hegemonic Masculinity", which defines what "real" men can or cannot do. Connell (1995) argued that within cultures there are a number of different masculinities that can be embodied, but that at "any given time one form of masculinity rather than others is culturally exalted" (Connell, 1995, p.77). Currently in the UK and in the West more generally, arguably the dominant notion of masculinity is characterised by suppression of needs, strength and not seeking help from others (Connell, 1995). Connell and Messerschmidt (2005) described how the theory of hegemonic masculinity is culturally dependent and inherently linked with power. The dominance of hegemonic masculinity serves to not only continue men's dominance over women, but also marginalises and oppresses other "subordinated" masculinities, such as men who are homosexual or those living with disabilities. Hegemonic masculinity (Connell, 1995) has been suggested to be important for understanding men's health behaviours (Courtenay, 2000), but others have critiqued for its lack of specificity as to the processes underlying how and why men may negotiate different versions of masculine identities across contexts (Wetherell & Edley, 1999).

#### *1.4.3.3. Masculinity and Mental Health in the Military*

The masculine environment of the military has been suggested to underpin MAF's and veterans reluctance to seek help for both physical and mental health difficulties. For example, Burns and Mahalik (2011) in their research cited typical masculine traits of self-reliance and emotional control as being particularly detrimental to MAF seeking support. This is illustrated by a participant in Murphy et al's (2013.p.6) study, who described the military way as being "cracking on despite a problem". Whitworth (2008) argues that emotions such as fear and pain contradict ideals of hypermasculinity and new recruits from their first moment in basic training are encouraged to suppress these feelings. Drawing on testimonies from American troops, she speaks of new recruits encountering an "onslaught of insults". These are often gendered, racist and homophobic and serve to promote hegemonic masculinity ideals whilst subordinating these other identities (Whitworth, 2008).

Other research has contested the power of hegemonic masculinity over veterans, concluding that masculinity is a context-dependent performance as some ex-servicemen appeared able to talk about mental health without apparent threat to their masculine identity (Green, Emslie, Neill, Hunt & Walker, 2010). Interestingly Green et al., (2010) observed veterans who had their hegemonic masculinity validated through their previous effectiveness as soldiers, were more able to tolerate becoming emotional whilst talking about their distress with others. Furthermore Caddick, Smith and Phoenix (2015) concluded hegemonic masculinity could serve as a resource for veterans, as military masculine norms of “getting on with it” and being self-reliant appeared to encourage them to seek help.

#### 1.4.4. The Military and Mental Health

Since the early 2000s there has been a surge in research exploring the impact of military life on mental health, well-being and family life in the UK. The majority of published research consists of large-scale epidemiological studies, typically investigating vulnerability factors (Iversen et al., 2005) and prevalence rates for distress (Fear, et al., 2010). These studies have highlighted the significant challenges facing MAF and their families both in coping with deployments, but also with adjusting to post-military life. Although quantitative studies have illuminated issues facing MAF, they tend to be cross-sectional in design and limit understanding causal factors in people’s distress. Furthermore they tend to rely on large samples of self-report questionnaire data and categorise these using the medical model, which preclude exploring the “uniqueness” in individual’s experiences. Critics (e.g. Summerfield, 2001) argue in respect to PTSD that these approaches obscure both the context surrounding a person’s difficulties and also how they make sense of them (in terms of their own beliefs and appraisals).

There are mixed findings as to whether veterans are more or less likely to have a diagnosable mental health difficulty than the general population. Some argue that there is no more greater risk for still-serving personnel than the general population (e.g. Brewin, Andrews & Hejdenberg, 2012), whereas others argued

MAF were twice as likely to report common mental health difficulties (Goodwin et al., 2015).

Woodhead et al., (2011) from their review concluded that veterans are no more likely to have a diagnosable mental health condition compared with non-veterans. However, differences in sampling across studies and findings that veterans may take eleven years after leaving the military to seek help, if they do at all (Murphy et al., 2013), may mean this finding is not truly representative. American research has discovered an increase in help-seeking once people left the military (Hoge, Lesikar, Guevara et al., 2002), which may be due to existing mental health issues, worsening distress due to the transition of becoming a veteran mental health or perhaps MAF feel more willing to admit their difficulties as they no longer feel the need to demonstrate resilience (Iversen et al., 2011) or hegemonic masculine ideals.

It has been widely agreed that relatively few MAF and veterans tend to access treatment, as it has been argued only 23% of MAF who meet criteria for a mental health diagnosis receive treatment (Iversen et al., 2010). Research suggests MAF are far more likely to attend appointments for physical health than mental health difficulties (Rona, Jones, French et al., 2004), suggesting physical illness remains more acceptable than that of the mental distress. It is likely veteran's reluctance to seek help has been impacted upon by historical discourses of shell shock and cowardice, along with the performance of hegemonic masculine ideals of soldiers as tough (Atherton, 2009). Murphy et al., (2013) in their research into veteran's help seeking for PTSD, found overcoming shame and having strong social support were key aspects in veteran's decision to access support.

#### 1.4.5. The Military and trauma

The history of PTSD and the military are inextricably linked, perhaps most famously with talk of soldiers returning with "shell shock" following the slaughter of the First World War. As Herman (2001, p20) comments, "one of the many casualties of the war's devastation was the illusion of manly honour and glory in battle". Not only did such sentiments lay the foundations for anti-war movements which continued throughout the 20<sup>th</sup> century, but also contested

hegemonic masculine ideals of warriors' strength and resilience in battle. Despite efforts to destigmatise trauma responses and increase awareness of mental health difficulties through the rolling out of Trauma Risk Management (TRiM)<sup>2</sup> in the UK Armed Forces, stigma surrounding a diagnosis of PTSD is still apparent today. Murphy et al., (2013) in their exploration of MAF experiences of PTSD found that appearing weak to their peers was a real concern for participants who had been diagnosed with PTSD.

#### *1.4.5.1. The nature of military traumas*

Larner and Blow (2011) argue military experiences of trauma cannot be compared to those of civilians, as the latter often stem from accidents or natural disasters not human violence. However (Herman, 2011) contests this arguing the prevalence of rape and abuse within the general population are frequently under-estimated. What is perhaps more compelling is the wider context to MAF exposure to traumas. Larner and Blow (2011) suggest that unlike most civilians, MAF are more likely to anticipate dangerous and life threatening situations as being part of their job and they have endured extensive training to prepare them for this. Young (1995) suggested MAF by choosing this career, may have self-selected themselves as people who seek out risk and danger. However MAF and veterans' responses to trauma may be further complicated by the morality of their work, as scenarios may cause them to confront and challenge their ethical beliefs about right and wrong (Larner & Blow, 2011).

Patel (2003) discusses how diagnostic labels of PTSD sanitises military experiences and silences scrutiny of the atrocities they may have been part of, but also witnessed in conflict. By focusing on trauma responses as a mental health problem, Patel (2003, p20) argues we fail to acknowledge the poverty, despair and slaughter people may have witnessed and that human rights abuses are made "startlingly invisible". There is a risk within research into PTSD in veterans that their search for meaning from their traumatic experiences may be overlooked (Summerfield, 2001).

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<sup>2</sup> TRiM is a psychological risk assessment and peer support system which aims to screen UK MAF who are at most risk for developing mental health problems and ensuring there are pathways to support (e.g. debriefings and access to psychological or psychiatric services). See Whybrow, Jones and Greenberg (2015) for a review.

#### *1.4.5.2. The “Deployment Effect”*

The relationship between the military, traumatic exposures and a diagnosis of PTSD is complex. Hughes, Cameron, Eldridge et al., (2005) concluded from studying elite UK combat units who took part in Iraq deployments, there was no increase in PTSD and they even recorded a slight improvement in mental health. But given that many trauma reactions seem to be either delayed or go unspoken for years, longitudinal follow-up would be useful to elaborate on whether this finding is still observed years later.

There has not been a consistent “deployment effect” found in the UK, as deployment to Iraq, Afghanistan or elsewhere has not been associated with PTSD, unless the MAF was in a combat role (Jones, Sundin, Goodwin et al., 2012). Jones, et al., 2012 concluded that lower rank, having had a serious accident, veteran status and experiences of childhood adversity were associated with PTSD. This research usefully highlights the complexity of MAF and veterans with a PTSD diagnosis, suggesting that PTSD experiences is more than just experiencing combat which many people and even professionals may assume. Whilst exposing experiencing a trauma is not indicative of PTSD, neither is going on deployment necessarily associated with trauma or PTSD.

#### *1.4.5.3. Veterans Experiences of Living with PTSD*

Much of the recent work in the UK into PTSD has been quantitative in design. However from their clinical work in America, Harkness and Zadar (2011) describe the impact veterans living with PTSD can have on families. They noted personality changes were especially challenging, perhaps from their beliefs about the world and their positive sense of self being shattered (Janoff-Bulman, 1992). Many spouses also reported finding veterans ambivalent in their relationships, oscillating between wanting to isolate themselves yet wishing to remain close to loved ones (Harkness & Zadar, 2011).

The complexity of veterans’ PTSD experiences is illustrated by Brewin et al’s., (2011) study, which reported a high prevalence of alcohol abuse which appeared to not only be putting veterans’ at risk, but also be impairing their social relationships. Harkness and Zadar (2011) also observed a vicious cycle



of emasculation which may occur in families. When a veteran leaves the armed forces, especially if they have mental health difficulties, they may be out of work for some time. Therefore partners may take on the emotional, financial and practical responsibilities of family life and “over-function” as a caregiver, whilst veterans may “under function”. This may not only lead to discord within the relationship and leave spouses exhausted, but may exacerbate feelings of shame, guilt and being emasculated, which may already be present in response to their trauma experience.

## **1.5. Recovery from Trauma Exposure**

Within civilian populations there has been increased literature concerning the phenomenon of “post traumatic growth” (Tedeschi & Calhoun, 1996), but notably, given the arguable differences in the nature of traumatic events that MAF experience compared the civilians (e.g. Lerner & Blow, 2011), there is a paucity of research within military populations. The following section seeks to unpick what the term recovery means from both individualised and social perspectives, before discussing post-traumatic growth and how it may be conceptualised with veteran cohorts.

### **1.5.1. Treatment Following Trauma**

Psychological interventions are recommended for the treatment of PTSD and Nice (2005) recommends Cognitive Behaviour Therapy (CBT). CBT practitioners often draw on Ehlers and Clark’s (2000) model (outlined in 1.3.4.3) to formulate and guide interventions which include processes of psychoeducation, exposure, cognitive restructuring and anxiety management (Bryant, 2011). However, CBT has been criticized for being inattentive to the meaning and wider context to traumatic events (e.g. Bracken, Giller & Summerfield, 1995) and in some cases Narrative Exposure Therapy is recommended as it supports people to narrate their trauma in a context rich story to support recovery (Schauer, Neuner & Elbert, 2011).

Herman (2001) advocated for the importance of group work in trauma services. She observed people to find strength and solace in meeting others who have

experienced similar ordeals, due to an intensely powerful realisation they are not alone. Harkness & Zadar (2011) in their work with Vietnam veterans cite involving family of veterans into therapy as incredibly useful, due to the difficulties veterans can experience in inter-personal relationships and in recognition of how social support can moderate the prognosis of PTSD's and support recovery (Bisson, 2009)

### 1.5.2. Deconstructing "Recovery"

Wilson et al., (2012) argues that whilst the large body of work discussing how trauma is conceptualised and understood is important, he makes a case for moving beyond psychopathology and illness dialogues to focusing more on discourses of recovery. This plea mirrors developments within other fields of psychiatry, whereby recovery has been a contested term for decades. Within mental health recovery discourses were originally pioneered in the 1980s by people with a diagnosis of schizophrenia who positioned themselves as "survivors" of psychiatry. The survivor movements spoke of recovery as a progress towards empowerment, coping with their distress and reclaiming an identity that was not defined by their diagnosis (Shephard, Boardman & Slade, 2008). Thus recovery discourses have historically challenged psychiatric diagnoses and the power professionals have in wielding them. Somewhat paradoxically given this context, recovery discourses have recently entered mainstream political and service lexicons (Bellack, 2006).

Defining recovery has long been problematic. In his widely used definition, Anthony (1993, p527) defines recovery as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/ or roles . . . a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness'. Whilst this description acknowledges the personal nature of an individual's recovery from mental distress, the use of illness as the cause means this process remains rooted in medical model discourses of mental distress being akin to a physical illness or disease (e.g. Anthony, 1993), obscuring social determiners of distress and well-being. Young and Ensing (1999) broadened recovery's meaning in their conceptualisation, positing

recovery as an individual's unique journey to over-coming 'stuckness', improving their quality of life and re-defining themselves following distress. Their research also highlights spirituality and supportive relationships with others with mental health difficulties as crucial to recovery, along with a return to basic functioning (e.g. taking care of oneself, eating etc.) as symbolic of being "recovered" (Young & Ensing, 1999).

This notion of recovery being a return to people's "baseline" functioning, is similarly expressed by Bonanno (2007) in his research into civilian's response to trauma. Whilst returning to "normal" is a state identified by some researchers as important to recovery and may be meaningful to some people following a traumatic experience, others argue processes that lead to new ways of being are integral to an individual's recovery following trauma. Whilst lesser explored with MAF and veterans, post-traumatic growth (Tedeschi & Calhoun, 1996) is a theory which is increasingly being drawn on to understand responses to trauma.

### 1.5.3. Post-traumatic Growth

Within PTSD literature resilience and recovery have been explored within civilian samples and interest in posttraumatic growth (PTG: Tedeschi & Calhoun, 1996) has increased. Their work drew on that of Janoff-Bulman's (1992) "shattered assumptions" theory following trauma. PTG has since been applied to people who experience positive life experiences after trauma such as a new appreciation for life, seeing new possibilities, enhanced personal strength, spiritual change and improved relationships and closeness to others (Tedeschi & Calhoun, 1996). Interestingly in their original paper Tedeschi and Calhoun (1996) noted that women were more likely to report PTG than men, which they theorised could be due to women relying more on PTG factors such as social support and spirituality to cope. Whilst they also suggested it could be that women are more able to "learn" from challenging experiences, it is possible that it is the method of extracting people's reflections on changes and the phrasing used in measures (e.g. about relying on others and showing emotions) biased against men due to their contradiction of hegemonic masculinity ideals. However gender differences have not been found in subsequent reviews, but higher socio-economic status, higher levels of education and younger age have

also been shown to be predictors for higher levels of PTG (Linley & Joseph, 2004). Tedeschi and Calhoun (1996) also noted that the severity of the trauma correlated with people's experience of PTG, as those who experienced the most challenging events reporting the biggest changes in their view of themselves and the world. But, as discussed, it is difficult to elucidate whether it is characteristics of the event that caused these changes or extraneous factors, such as if the person has a good social support network or of whether they were someone who by nature relishes new experiences and challenges.

#### *1.5.3.1. PTG in American veterans*

Little research has been undertaken into the experiences of PTG in UK military veterans, although data from America suggests that within veterans with PTSD, higher levels of PTG were associated with better functioning and general health (Tsai, El-Gabalawy, Sledge, Southwick & Pietrzak, 2015). This study also supported the validity of PTG as a concept, as PTG was higher in US veterans with a diagnosis of PTSD than veterans without. Whilst PTG is not always associated with experiences which would be termed "trauma" and result in PTSD, the work of Tsai et al., (2015) suggests exposure to difficult events facilitates growth above what may be expected than in the general military population.

#### *1.5.3.2. PTG in UK veterans*

Literature has tended to focus on the negative impact from traumatic exposure, with lesser attention paid to possible positive effects and PTG. In Brewin, Garnett and Andrew's (2011) study with MAF, they completed a qualitative analysis of MAF's ad hoc comments about their lives post PTSD treatment. Themes emerged of relationship enhancement, a new appreciation for life and a more positive self-perception, which are similar to PTG. Although a thorough exploration of MAF's recovery experiences was not this study's aim, it is limited by its lack of exploration of the factors which may have brought about these changes. It also used a veteran sample that had completed treatment many years previously, which makes it difficult to compare their pre and post treatment lives.

#### 1.5.4. Critique of recovery literature

#### 1.5.4.1. *Recovery, resilience or PTG?*

Arguably recovery, resilience and PTG are all terms which are open to confusion and conflation. Bonnano, Galea, Bucciarelli and Vlahov (2007) distinguish resilience from recovery by stating that resilient people may experience a short-term dysregulation in their emotional and physical well-being after a traumatic event, this does not impact significantly on their lives and they soon return to “normal” functioning. Meanwhile they argue recovery pathways are characterised by increased psychological symptoms which may last several months, before returning to pre-trauma functioning (Bonnano et al., 2007). Whilst defining these different terms is useful for having a shared language for research, they suggest resilience to be mutually exclusive with distress, yet others (e.g. Herman, 2001; Patel, 2003) may argue trauma survivors show immense resourcefulness and capacity for survival.

Much of this research is Amerocentric and there is also a lack of understanding as to the processes which support recovery and resilience. What is shared between much of the literature on PTG, resilience and recovery is the emphasis on the individual’s propensity to change their thoughts, beliefs and how they make sense of their lives following trauma; But by focusing on the individual’s ability to cope in a way which brings about positive changes, the potentially isolating, oppressive and challenging day to day contexts in which people live and may be serving to prolong their distress following disaster, may be overlooked.

#### 1.5.4.2. *PTG as Eurocentric concept*

Whilst PTG is likely to characterise some people’s experience following a traumatic experience, the assumptions under-pinning it are laced with Western views on survivorship and coping. As Summerfield (2002) stated when writing about those who have experienced war, Western ideas of recovery spawning from catharsis and sharing stories may be inadequate; Summerfield (2002) argued instead that the key to recovery may be the resuming of practical and perhaps mundane processes of day to day life. He continued to argue that economics and social justice are inextricably linked to recovery following trauma and thus individuals may not individually hold the power to make this change.

Summerfield (2001) noted that resuming or discovering cultural and religious patterns of life may be important for people to cope with traumatic events, which has in fact been theorised as important within concepts of PTG (Tedeschi & Calhoun, 1996).

Summerfield (2002) continues to question psychologists' usage of words such as processing, acceptance and "coming to terms with the past" when discussing recovery particularly in the context of war. He posits such language reproduces and sustains discourses that recovery is something akin to physical illness which can follow a mechanistic treatment process. Pupavac (2002) similarly noted there is a tendency in western therapies to talk about people being "in recovery", but never recovered –perhaps due to the difficulties in measuring this concept. Such discourses not only ignore the individual nature of responding to a trauma but also how that person recovers, and implies a deficiency in those who do not accept, process or come to terms with their past through therapy. As Bracken, et al., (1995) argue, recovery is not merely a psychological process but also a reconstruction of social and economic networks, cultural institutions and human rights. Given the unemployment concerns of many veterans with mental health difficulties (Iversen, et al., 2005b) and the "reverse culture shock" (Bergman et al., 2014) of returning to civilian life, the social account of recovery may offer a meaningful critique of PTG for the veteran experience.

## **1.6. Research Aims**

Currently there is a dearth of qualitative research into the lived experience of UK veterans who have been diagnosed with PTSD and how they make sense of their recovery. This study seeks to address the current gap in the literature to explore pathways to recovery in veterans who have had treatment for a diagnosis of PTSD and investigate their perspectives on their lives following treatment.

It is hoped this study will provide useful insights into recovery for clinicians working at this particular treatment centre, but also for practitioners working with veterans within other settings (e.g. NHS). More widely it is hoped this research may inform the theoretical knowledge base surrounding recovery in MAF and

veterans.

With the above aim in mind, the research questions were framed as:

- How do veterans make sense of their lives following a diagnosis of PTSD?
- What factors have facilitated their pathway to recovery?
- What challenges have they experienced during their process of recovery?

## **CHAPTER TWO: METHOD**

### **2.1. Overview**

This study aims to explore MAF experience of recovery following treatment for PTSD. The qualitative methodology Interpretive Phenomenological Analysis (IPA) developed by Smith (1996; Smith & Osborn, 2008) will be used to meet these research aims.

### **2.2. Research Design – A Qualitative Approach**

As outlined in chapter one, there is a paucity of research into the lived experience of veterans who have been diagnosed with PTSD and how they make sense of their diagnosis and lives following treatment. Qualitative research within this area would allow for the personal and social experiences of the individuals to be explored, described and interpreted (Smith, 2008). A qualitative method fits with this study's inductive approach to understanding a relatively small sample of individuals' experiences in depth, rather than striving to falsify a pre-determined hypothesis (Smith, 2008). A qualitative methodology lends the researcher opportunities to explore in depth the meaning of the person's experience and how they make sense of it (Larkin & Thompson, 2012).

### **2.3. Epistemological Framework**

In this research an IPA methodology was chosen for analysis. IPA has a hermeneutic phenomenological epistemology which lends itself to exploring questions relating to how a person experiences and relates to the world, which is the primary concern of this research. An IPA methodology allows the researcher to explore how MAF have experienced both diagnosis of PTSD and their subsequent recovery process, and develop an understanding of what has uniquely helped or hindered them.



### 2.3.1. Origins And Theoretical Underpinnings of IPA

IPA is an inductive approach which seeks to privilege the accounts of the “experts” (the participants themselves) and how they make sense of their experiences. IPA researchers comment from participants’ own accounts of their phenomenological world on meaning, cognition, affect and action (Reid, Flowers & Larking, 2005). Whilst IPA has been used extensively in health psychology, it is considered a useful methodology to explore a variety of psychological enquiry (Larkin & Thompson, 2012).

In IPA the researcher assumes that people are actively interpreting events, objects and people which they encounter in their lives (Smith & Osborn, 2008), and draws on theories of phenomenology, hermeneutics and idiography to explore these interpretations.

#### 2.3.1.1. *Phenomenology – The study of “being”*

A “phenomenological” stance is one in which the researcher attends to the person’s stories and privileges their perspective at the core of the account (Reid et al., 2005). Phenomenology seeks to understand individual’s experiences of being human and what matters to them and how they understand their world (Smith, Flowers & Larkin, 2009). Therefore in phenomenological analysis the researcher is curious as to how the person talks about objects and events and what they mean to them, instead of reducing descriptions of their experience to predetermined categories or scientific constructs (Larkin & Thompson, 2012).

#### 2.3.1.2. *Hermeneutics – The “theory of interpretation”*

Hermeneutics “the theory of interpretation” is another key influence on IPA (Smith et al., 2009). The study of hermeneutics queries whether the researcher can understand and ever truly know the original intentions and meanings of the author (Smith et al., 2009). Hermeneutics highlights the active role of the researcher in hearing and interpreting others’ stories and is interested in the differing contexts in which the individual’s story is told and in which it is heard, interpreted and translated by the researcher. Thus hermeneutics emphasises the dynamism of IPA and how there is a dual interpretation process, as participants will initially make meaning of their world and researchers then try to make sense of the participant’s meaning making (Larkin & Thompson, 2012).

IPA research therefore promotes the self –reflexivity of the researcher as an important process throughout research, as within IPA (and some other qualitative methodologies) data collection is not deemed a neutral endeavour (Rapley, 2001) and undoubtedly will include some subjectivity. Through self-reflexivity the researcher seeks to understand how the questions they ask, their interests and own context influence what stories are heard, interpreted or focused upon in the research and also the conclusions made (Larkin & Thompson, 2012). The conclusions the researcher draws should be grounded in examples from the raw transcripts and be plausible to participants, supervisors and also general readers for research integrity and validity (Reid et al., 2005).

#### 2.3.1.3. *Idiography- the study of the individual's perspective*

The third theoretical influence which IPA draws on is idiography, which is concerned with extensive study of the individual's perspective within their unique context (Larkin & Thompson, 2012). IPA research is interested in the specific rather than the general and is curious about how a particular phenomenon (such as a process, event or relationship) has been made sense of by particular people in a particular context (Smith et al., 2009). This contrasts with many quantitative studies in psychology which seek to make claims about a group, which may lead to the development of universal theories or laws about human behaviour (Smith et al., 2009). The engagement with individual's accounts extends throughout the analytic process. The researcher will shift between examining themes which arose in the analysis and demonstrate them with quotes from the individual's narrative, seeking to compare and contrast how individuals tell their stories and the similarities and differences between them (Larkin & Thompson, 2012).

## 2.4. Study Development

During the planning phase of this project the researcher approached Combat Stress to collaborate on this study. The researcher consulted with her University supervisor and it was agreed it would be useful to recruit from a service which had shown an interest in the project and also willing to collaborate in its development. The researcher presented the study's proposal to Combat Stress

clinicians and invited their feedback, which helped boost the profile of the study and promoted recruitment.

#### 2.4.1. The Interview Schedule

IPA research generally requires a first person account, which is often gleaned from a semi-structured interview (Larkin & Thompson, 2012). This study's interview schedule (Appendix 5) was constructed from studying relevant literature (e.g. Smith & Osborn, 2008) and through supervisory discussions. The interview aimed to privilege participants' perspectives on receiving a diagnosis and what they had found helped or hindered their recovery, and also what recovery meant for them. Therefore the interview schedule was designed as a framework, not a prescribed order of questions. This flexibility sought to allow participants to tell their stories in their own words and draw on experiences which they felt fitted with the questions.

#### 2.4.2. Inclusion and Exclusion Criteria

The inclusion criteria for this study are partially determined by the inclusion and exclusion criteria for Combat Stress' treatment programme. Therefore participants must have been exposed to two or more traumatic experiences (one of which must be related to military service), have a diagnosis of PTSD and also have served in the Armed Forces for at least one day. To access this treatment programme veterans must not be diagnosed with a personality disorder, be currently dependent on alcohol, exhibiting symptoms of psychosis, feeling suicidal or have a suspected traumatic brain injury. Given the study's interest in constructions of masculinity within military culture only men were recruited.

#### 2.4.3. Pilot Interview

The first interview was constructed as the pilot and the researcher asked the participant for feedback after and whether he had ideas for improvements of what could be done differently. Whilst he did not have any suggestions, following supervision the researcher reflected on how to use prompts in interviews (e.g. being careful to avoid leading questions). The pilot interview was included in the final analysis.

## **2.5. Ethical Considerations**

### **2.5.1. Ethical Approval**

Ethical approval was sought and granted from the University of East London (see Appendix 2) and Combat Stress's independent ethics committee consented for the researcher to recruit from their treatment centre.

### **2.5.2. Informed Consent**

The researcher went to Combat Stress and presented the study to potential participants at the end of one of their group sessions. Afterwards they approached her to express an interest and ask questions. Participants were given an information sheet about the study (Appendix 3) and the researcher collected a signed consent form (Appendix 4) from participants. Participants gave their permission for the researcher to contact them on an agreed date in two to three months' time for one semi-structured interview over the telephone. This time point was chosen to allow people to reflect on recovery over the longest time span since treatment, which was feasible within the project's time constraints.

The researcher visited Combat Stress twice to recruit participants who due to the treatment course, were all veterans not currently serving MAF. On the first occasion six veterans consented to take part and four continued to complete the interview. The researcher was unable to contact the other two participants by telephone or email. On the second occasion the researcher recruited six participants from Combat Stress, five of whom were later contactable and completed the interview.

### **2.5.3. Confidentiality**

Participants were made aware both when they signed up to the study and also at interview that their data would be confidential. Only the researcher has access to the names and contact details for participants, which were held in a password protected file. In the write up of this study pseudonyms were used and any identifying information removed to protect people's identities.

Participants were informed their interviews were recorded, but only the researcher listened to their tapes to type up into transcripts. They were also made aware the researcher's University supervisor would have access to anonymised transcripts to support with analysis and write up, but not the researcher's Combat Stress supervisor and collaborator.

The limits to confidentiality were discussed with participants before interviews and they were told if the researcher were to have concerns about their welfare or safety then Combat Stress would be informed.

#### 2.5.4. Affiliation of the researcher

At interview the researcher explained to participants that she was not affiliated with Combat Stress and that withdrawing from the study would not have any bearing on any future treatment at the charity. This was also highlighted when the researcher originally met the participants and on the information sheet. At interview the researcher reminded participants that taking part was entirely voluntary. The researcher also acknowledged that whilst conversations may lead participants to reflect on their treatment at Combat Stress, it was emphasised that this study's aim was not to evaluate this but learn about their experience of diagnosis and recovery more generally.

#### 2.5.5. Potential Distress

When developing this study the researcher and supervisor considered how to limit re-traumatisation or distress for participants, should interviews lead them to reflect on past traumatic events. To limit this risk, participants were explicitly told that the study's questions were not seeking to hear about past traumas, nor were they obligated to answer every question if this felt difficult. The researcher is a Trainee Clinical Psychologist with experience of working with people who have experienced trauma or intense distress and took care to conduct interviews in a sensitive and thoughtful manner and put interviewees at ease as much as possible. Participants were also reminded they could take breaks and time was allowed at the end of interviews to debrief.

Interviews were conducted over the telephone and during standard working hours, so the researcher felt confident of being able to seek support if required.

The researcher undertook one interview on a Saturday morning and informed her supervisor that this was taking place.

Despite these identified risks, overall the researcher and supervisors hoped this study would provide an opportunity for veterans to make sense of their experiences and reflect to an empathic listener about their life following treatment. It was also thought that participants may value this opportunity to share their experiences in their own words, in order to hopefully help others in the future.

## **2.6. Method of Data Collection**

### **2.6.1. Recruiting from Combat Stress**

All participants were recruited from the charity Combat Stress, which is one of the largest treatment centres for veterans living all over the UK who may have a diagnosis of PTSD. Recruitment from Combat Stress enabled the researcher to engage participants who had all served in the armed forces and received treatment for PTSD and therefore had the relevant lived expertise for the research aims. Combat Stress leads a voluntary, comprehensive six week treatment course for veterans who have been diagnosed with PTSD which includes psycho-education and skills training (e.g. Mindfulness, cognitive-behavioural therapy techniques), as well as individual trauma –focused psychological therapy. Veterans stay at Combat Stress in Leatherhead for the entire six weeks and are encouraged to engage in different groups and one-to-one sessions.

### **2.6.2. Participants**

Smith et al. (2009) suggested for IPA research at professional doctoral level that up to ten participants may be interviewed. However, it has also been argued that fewer interviews can be used if there is significant richness and depth to the data to enable meaningful conclusions to be drawn about points of similarity and difference. At a minimum the researcher sought to interview six participants, which is in keeping with some published IPA studies which have a sample size of six people or less (Smith et al., 2009).

To increase the homogeneity of the sample, the researcher approached potential participants to take part in the study in the final, or second to final week of their six week intensive treatment programme. This time was chosen as Combat Stress were concerned it may be disruptive if the researcher attended a group session too early in the treatment course, but it was also thought veterans may be more open to thinking about recovery and life after Combat Stress towards the end of treatment.

The researcher went to Combat Stress twice to recruit participants and sought consent from more people than was required for the study, due to concerns the time delay between recruitment and interview may lead to people withdrawing. The researcher attempted to contact all participants between two to three months following recruitment to request an interview. If participants could not be contacted, then the researcher emailed or texted them once to offer an interview. If she did not hear back from participants within two weeks, it was assumed they no longer wished to take part and the researcher texted them again to explain they would not be contacted for this research again.

All participants who took part identified as male and White British or English.

**Table 1: Socio-demographic characteristics of participants**

<b>Name<sup>3</sup></b>	<b>Age</b>	<b>Relationship status</b>	<b>Employed?</b>	<b>Previous Service</b>	<b>Rank (Officer or in Ranks)<sup>4</sup></b>	<b>Years in military</b>	<b>Year left</b>
John	40-49	Married	Yes	Army	Ranks	23	2010
Dave	30-39	Partner	Yes	Army	Ranks	5	1997
Simon	50-59	Widower	No	Navy	Ranks	19	Missing <sup>5</sup>
Mark	40-49	Partner	Yes	Army	Ranks	20	2005
Craig	30-39	Single	No	Army	Ranks	14	2012
James	30-39	Married	Yes	Marines	Ranks	11	2014
Tom	40-49	Single	No	Army	Ranks	3	2013
Nick	30-39	Single	Yes	Army	Ranks	4	2005
Bill	60-69	Married	Retired	Air Force	Officer	40	2013

<sup>3</sup> All participants were given pseudonyms to protect their identity

<sup>4</sup> Ranks or officer sub-categories were used to protect participants' identity.

<sup>5</sup> This participant gave an unfeasible year in which he left service, which was only realised during write up and the researcher has been unable to contact him for clarification.

### 2.6.3. Interviews

Interviews took place at a time of the participant's choosing two -three months following their treatment at Combat Stress. All interviews were administered over the telephone, due to the practicalities of MAF living all over the UK. A review comparing research into the validity of telephone versus face to face interviews found few differences in consistency and quality of data between these modes (e.g. Bowling, 2005). Telephone interviews are also recognised as a feasible data collection tool for qualitative research (e.g. Cachia & Millward, 2011). The researcher did not observe difficulties in building rapport with participants during the interview, but acknowledges that speaking over the telephone did appear to discourage one person from taking part due to confidentiality concerns about speaking over the telephone.

Interviews were undertaken on speakerphone and recorded on a digital voice recorder. The researcher undertook all interviews whilst home alone, so the interviews would not be overheard. Interviews began by the researcher reminding participants of confidentiality and that they could withdraw or take breaks at any point and they were welcome to ask questions. The researcher also sought to build engagement with participants through small talk, before asking participants for demographic information (e.g. age, ethnicity etc.) at the beginning of the interviews.

The main interview used a semi-structured interview (see appendix 5) and lasted between 45 and 70 minutes, depending on participant's engagement with questions. After the interview the researcher sought feedback from participants and asked for any further reflections they wished to offer. No participants indicated distress during or after the interview, but had this been a concern the researcher would have signposted them to their GP or Combat Stress as appropriate.

Following each interview to increase reflexivity the researcher recorded reflections and thoughts that came to mind during the interview, considering any themes and process issues in note form and in a reflective diary (see Appendix 8). The interviews were then typed by the researcher into a transcript for analysis.



## **2.7. METHOD OF DATA ANALYSIS**

IPA was used to analyse transcript data from interviews, as outlined by Smith et al (2009) and Larkin and Thompson (2012). Guidelines for quality in qualitative research (e.g. Elliot, Fischer & Rennie, 1999) also informed this procedure, including the importance of reflexivity, striving to create a coherent and plausible narrative and drawing on peer and professional supervision.

### **2.7.1. Rationale For Choosing IPA**

As outlined, IPA was chosen as a suitable method of analysis for several reasons:

1. IPA is interested in meaning and process, opposed to events and their causes (Larkin & Thompson, 2012). Instead of uncovering an objective reality, IPA seeks to capture the experience of individuals as they have constructed it. Thus in IPA, it would not be assumed that constructs such as “recovery” or “PTSD” would hold the same meaning for different people. In this way IPA holds a spotlight on the individual level of analysis rather than the general.
2. IPA with its focus on phenomenology and the study of “being”, is consistent with the research aims of understanding the lived experience of living and recovering from a diagnosis of PTSD from the viewpoint of MAF themselves.
3. Other methodologies were explored in the early stages of the study’s development, but IPA with its phenomenological lens to individual’s experience was deemed most suitable. Other methods such as grounded theory, discourse analysis and thematic analysis were considered (e.g. Harper & Thompson, 2012). However as the thrust of the research question became phenomenological in nature, other methods were discarded as this research neither seeks to develop an explanatory theory of recovery from PTSD, nor has specific focus on the language and discourses surrounding these constructs.
4. To date there have been no published studies into how MAF make sense of being diagnosed with PTSD and their pathways to recovery using IPA.

### 2.7.2. Approach to analysis

The transcript data were analysed using steps outlined by Smith et al (2009) and Larkin & Thompson (2012). Individual transcripts were analysed one by one, to enable the researcher to attend to the concerns of the particular participant. Analysis was supplemented by supervisory discussions with an experienced IPA researcher and a peer researcher who was also using an IPA methodology in their research.

#### 2.7.2.1. *Initial engagement with the interviews*

The researcher began to engage more thoroughly with the interview material through repeatedly listening to them whilst transcribing. Once the interviews had been typed into transcripts, the researcher read each interview through many times and made running commentary notes (see Appendix 6). These included notes on what appeared to matter to participants, including their claims, concerns and understandings (Larkin & Thompson, 2012) and their use of language and the associations this conjured up for the researcher.

#### 2.7.2.2. *Initial coding*

The researcher then re-read the transcripts and noted emerging patterns and themes in the left hand margin of the transcript. These noted commonalities and nuances within the text and were a higher level of abstraction. This led to reflection from the researcher as to how the coded data may be made sense of in light of psychological knowledge and the participant's and researcher's contexts. Emergent themes for each transcript were then collated into a table.

#### 2.7.2.3. *Searching for relationships across themes*

The next phase utilised a more analytic approach, as the researcher strove to make sense of connections between themes (noting commonalities and differences) and clustering them together. The theme clusters were given a descriptive label aiming to capture the meaning from the text and formed the superordinate themes. This process was cyclical, as the researcher repeatedly checked her interpretations and themes with the original text. A table of superordinate and subordinate themes and corresponding quotations from transcripts was produced (see Appendix 7 for an example).

#### 2.7.2.4. *Final list of themes*

Once a table of themes had been produced for all nine interviews, a final table of themes was constructed from all of the interviews. Themes were clustered into superordinate and subordinate themes and the researcher again referred back to transcripts to reflect on the original context and meaning of the excerpts. In this process some themes were prioritised over others, which may be due to their being well-represented within the text, highlighted as especially significant by participants, or the complexity and richness of the excerpts, as well as their relevance to the research question (Smith, 2008). The researcher used supervision (both from a UEL tutor and from a fellow trainee also completing IPA research) and a reflexive diary to assist with decisions at every step in this process, which was then expanded into the narrative account which is the basis for the Results chapter.

### **2.8. Researcher reflexivity**

#### 2.8.1. Why is self-reflexivity important?

In qualitative research it is assumed that the researcher and participants are not independent entities and it is therefore impossible for researchers to be completely objective and set aside their own assumptions and beliefs when making sense of data (Willig, 2013). To attempt to address this and preserve academic rigour, qualitative researchers seek to “own” their perspectives and values through self-reflection to offer readers an opportunity to consider alternative interpretations (Elliot, et al., 1999). To acknowledge the impact of the researcher in shaping the focus and interpretation of analysis, the remainder of this thesis will be written in the first person to allow for greater transparency.

#### 2.8.2. Statement of my position in this research

I am a 29 year old White British woman who has worked in psychology (both clinical and research teams) for the past seven years. I grew up near a naval base at Portsmouth and many of my friends from school went on to serve in the forces. My father is very interested in the armed forces and volunteers at a military museum, and so since my childhood military culture has seeped into many aspects of my life.

Professionally my first experience of working with military servicemen was when I was a Research Assistant. My role was to interview MAF and veterans to establish whether they met threshold for a research diagnosis of PTSD. I remember being struck during this project of the diverse ways in which MAF and veterans made sense of their difficulties and the limitations of the quantitative research I was undertaking. I felt frustrated that the richness of MAF's accounts had been reduced to psychiatric symptoms, which did not incorporate any context of people's difficulties. In these interviews I was repeatedly struck by many veterans' sense of duty, struggles to adjust or relate to civilian life and a pervasive sense of shame surrounding admitting to having any form of mental health difficulty.

This experience greatly affected me and inspired me to become increasingly curious about alternative approaches to psychiatric diagnoses which has continued to throughout my clinical training at the University of East London. When I was given this opportunity to undertake this research, my thoughts immediately went to my time working with veterans and I decided I wanted to undertake a project which in some manner would "give voice" to their experiences.

During my clinical training I have worked with many different clients and whilst I would position myself as having a critical approach to psychiatric diagnosis, I have also witnessed first-hand that diagnosis can feel incredibly useful and meaningful for people. I therefore strove to conduct these interviews with an open mind and a position of curiosity, striving to discover how participant's themselves made sense of diagnosis and recovery; If diagnosis was helpful for recovery, then why was it and how did it help? Also what else was helpful, or unhelpful in their recovery journeys?

## CHAPTER THREE: RESULTS

This chapter details the results of an interpretative phenomenological analysis of nine male veterans' experiences of recovery following treatment for a diagnosis of PTSD. Four superordinate themes emerged to form the basis for an analysis:

- Relief of receiving a PTSD diagnosis
- From layman's knowledge to the technical ins and outs.
- A changing relationship with self, the world and others
- The road to more recovery and less suffering

Table 2: Summary of sub-ordinate themes which contributed to these super-ordinate themes:

<b><u>Super-ordinate theme</u></b>	<b><u>Sub-ordinate themes</u></b>
<b>Relief of receiving a PTSD diagnosis</b>	<i>Breaking the silence</i>
	<i>A big answer to a lot of my problems</i>
	<i>Reassurance I wasn't going mad, or horrible...</i>
<b>From layman's knowledge to the technical ins and outs</b>	<i>The shot at dawn associations</i>
	<i>You have to surrender and go with it</i>
<b>Recovery: A changing relationship with self, the world and others</b>	<i>No longer suffering alone</i>
	<i>My relationship with me</i>
	<i>A squaddie in civvy street -</i>
<b>The road to more recovery and less suffering</b>	<i>You're always going to have your demons</i>
	<i>Taking on PTSD</i>
	<i>From isolation to reconnection</i>

These themes will be explored in a narrative account of how veterans' made sense of their recovery after treatment for a diagnosis of PTSD.

### 3.1. Relief of receiving a diagnosis of PTSD

Most participants described their emotions and behaviour as feeling out of their control prior to diagnosis. Many recalled feeling overwhelmingly distressed, which led to fears they were "going absolutely insane" (Mark) or there was

something intrinsically wrong with them or that they were “weird” (John). Despite PTSD being a mental health condition, interestingly many participants spoke of their PTSD diagnosis giving them reassurance that they were experiencing “something normal” (John) and that they were “not going mad” (Dave). Furthermore for many of the participants being given a diagnostic label appears to have validated their experiences that there was something “officially wrong” (James) and gave them a framework to understand their symptoms in the context of their military experiences. Crucially diagnosis also appeared to also offer most participants some hope that they might be able to “move towards a solution” (Nick), which came as a huge relief.

Five participants described specific “flash points”, where they realised their only option was to seek help for their difficulties, or risk losing families, partners or the chance of relationships and meaningful work in the future. For others the pathway to seeking help was less dramatic, but still meant overcoming fears of stigma and admitting they needed support. One of the participants likened this to tackling “Mount Everest” (John), after years of suffering and feeling ashamed about their uncontrollable emotions and behaviour.

Across participants’ accounts there is a shared sense of relief from eventually sharing their problems with a professional who appeared to understand their difficulties. For some participants this came after years of silence about their problems or struggling to engage with statutory services.

#### 3.1.1. Breaking the silence

The relief of opening up and telling someone about their difficulties was identified by some participants as a key moment in their progress towards recovery:

*As soon as I started off-loading, it just got easier and easier, and... I've uploaded everything now and that's it. Definitely talking about it is the initial ...massive thing to do— it's not the answer... 100%, but until you do that... you can, that there is somebody there who will listen and once you realise that, you are on the road to recovery (John).*

John pinpointed talking as a key moment in accepting he was having difficulties and taking steps to address these. John describes talking as instrumental in alleviating some of his sadness and freeing him from the power of his memories

*I'm... nowhere near as sad as I was. I can talk about the problem (John).*

For him sharing his experiences for the first time was a powerful moment, as he repeatedly made reference to how his traumatic experiences had become a burden he bore alone and led to him feeling intense sadness and isolation. All participants described a sense of loneliness in their distress prior to diagnosis, which for most had been abated since treatment and they had shared their difficulties with others.

John explained he suffered in silence because he wanted to protect his loved ones from his horrific experiences and not let them down by admitting “weakness”, by showing he had been emotionally affected by his experiences. John reflected how his fears were exacerbated by traditional masculine norms discouraging the displaying of emotion, which another participant described as “chin up, don’t cry” (Craig). Such masculine ideals were particularly affirmed and embodied within the military:

*You’re always told military wise, the first thing is grin and bear it, chin up, we don’t do that sort of thing in the army... (John).*

Whilst not all interviewees reflected in depth about how they had been impacted upon by masculine norms and ideals, in different ways they all discussed how talking about emotions and acknowledging distress contradicted their identity as strong, tough warriors:

*I think the military back ground of..of..you don’t sort of whinge about things, you don’t bitch and moan...[break] ... you didn’t want to show a level of weakness (James).*

James speaks directly about how talking about his distress in the army would have likely been negatively perceived as whinging and moaning, and using the word “bitch” further aligns these activities as both undesirable, but also female characteristics. He continues to address how talking is framed as a female prerogative in the military and unsanctioned with male colleagues:

*There were girls around, so there were females to talk to...[break]...you were very much in that remit of being you’re with the lads and this is how you’re expected to behave (James).*

James initially describes female colleagues as “girls”, which positions them as perhaps weaker or more delicate, before he switches to “females”. Other participants in their accounts discussed the nature of “lad” behaviour of black

humour and teasing one another meant coming forward with difficulties whilst in the forces was virtually inconceivable for them. James later reflects as a veteran he left this “macho environment”, which helped him be more open about his difficulties.

Not disclosing difficulties whilst in the army not only preserved respect and inclusion with colleagues, but as Mark described was also due to him prioritising duty and not wanting to let others down by leaving to get treatment whilst in the forces:

*I think it's primarily a male environment. You know, you're a team, you've got this feeling you know, if you pull out for any given reason you're sort of letting the other guys down. (Mark)*

Thus in the forces stigma to help seeking appear exacerbated by fears of letting colleagues down, which may be amplified by being in positions of responsibility as an officer or medic like James. Thus for most participants speaking out whilst in the services seemed virtually impossible and some of them had lived with their difficulties for more than twenty years before seeking help. Mark describes how due to shame he had previously struggled to disclose to professionals his problems:

*I didn't tell them I was self-harming, I had been for 20 years- were the things I should've said which would have giving them the markers, so they didn't really spot it and ...[break]... just my lack of honesty and I was quite ashamed to sort of let people down you know, so I just didn't sort of get the help (Mark)*

A sense of shame in seeking help filtered through many participants' narratives. Five veterans explicitly named fear of losing relationships or “hitting rock bottom” in a “shit storm” of emotions which in two instances led to attempts to take their own lives, as motives for overcoming their prejudices and finally seeking help.

### 3.1.2. “A big answer to a lot of my problems”

All but one participant suggested diagnosis was important for finding a much needed understanding of why they were experiencing their difficulties. Veterans described gathering their own understanding of PTSD at different points from diagnosis to treatment. The support from a professional who appeared knowledgeable and to understand them was identified by most of the participants as being key to this process. For many of the participants gaining



an understanding of how PTSD fitted in their lives, lead to reflections on how life was prior to diagnosis:

*It made me understand why I was ... apathetic about things, why I was, getting angry about things, why I wasn't bothering to get up in the morning... why I just erm... hide myself away really... I used to spend... hours at a time really, just going nowhere. Just out for a walk, thinking about nothing... (Simon).*

*I had been having quite a few problems previous to the diagnosis sort of, you know mood, aggression, relationship problems things like that (James).*

For seven of the nine participants, a diagnosis of PTSD almost immediately appeared to be received as a helpful framework to understand their difficulties in their mood and relationships.

*It did just make me stop and think, scuse my French, holy fuck, yeah that's me all over, all the things that they were asking me about, when I gave him the answers and they were ticking them off as signs of PTSD.... And it's all sort of fitted together (John).*

John described how this mechanical sounding process of his symptoms being ticked off, for him induced a powerful response that he finally had a coherent explanation of what he had been going through. Three more participants also highlighted how receiving the diagnosis not only formed an “answer”, but also gave them a sense of professional validation there was something “officially wrong” (John) with them.

*To have somebody with letters after their name saying the reason that you've done this and been like this is because of this, it's kind of a nice...(Tom)*

The expert with “letters after their name” may be especially important in veterans' accounts due to the hierarchical culture of the military and the deference shown to those of higher rank, education and responsibility. Thus hearing this explanation from a professional may have felt especially validating of their difficulties.

For Nick and Bill, making sense of their problems with a diagnosis of PTSD was a more complex path. At interview Nick could not recall having PTSD explained to him or being officially diagnosed. Unlike other participants Nick recalled feeling confused and like an “imposter” during treatment, which he felt made it more difficult for him to engage. For Bill, support to make sense of the diagnosis was especially important:

*I had some of the symptoms of PTSD, but I didn't have any of the...causes of PTSD so, it was anxiety with really no idea of why I had anxiety (Bill)*

Bill experienced multiple stressors in his military career, but could not recall one particular trauma. Bill spoke of previously meeting with various professionals who differed in their opinions of what was “wrong”, which appeared to leave him feeling disbelieved and prevented him from obtaining appropriate treatment.

*Three or four psychologists have ... poured doubt on my diagnosis on several occasions because I didn't have any visual flashbacks (Bill).*

Bill in this excerpt highlights how he did not have flashbacks which are one of the criteria for PTSD diagnosis, which led to debate amongst professionals about his diagnosis. However at interview Bill appeared to now be identifying with the diagnosis and spoke of how he had come to an understanding that whilst he may not have experienced “typical” traumatic events, he still had PTSD. As with other participants Bill appeared to find support from knowledgeable professionals, who acknowledged and validated his difficulties as important to making sense of his diagnosis.

### 3.1.3. Reassurance I wasn't going mad, or horrible...

Four participants spoke about their fears prior to diagnosis that their problems including frustration, anger, anxiety, low mood and even suicidality, denoted madness or insanity. However despite PTSD being a mental health diagnosis, receiving the diagnosis appeared to offer many participants a feeling of reassurance that they were in fact “not going mad” (Mark). Whilst most participants spoke openly about being diagnosed with a mental health condition which they conceded might be stigmatised against in some contexts, they appeared to make sense of PTSD as “normal” given their military training and traumas they had gone through:

*I always thought it was erm...just people being weak...until, until I was shown that it isn't, because now, I know, I know it's pretty normal (John).*

*The biggest thing, was knowing about the diagnosis, knowing the reason for why I was like I was, were completely normal given the situation. And it wasn't me going round the bend (John)*

Therefore a PTSD diagnosis appeared to give participants an understanding that their difficulties were rooted in their military career or trauma exposure, not the result of an uncontrollable madness or personality change which had felt

embarrassing and terrifying. Many recalled worries they were being “weird”, a “dick” or just “horrible”. Not only did the diagnosis explain the symptoms, but also offered hope that treatment might support them to cope with their difficulties and life would be different in the future.

*It wasn't just me ... and it was just me being...oh you know, my personality. It wasn't just me being... erm it was something I could get rid of, or perhaps or deal with... or at least control (John).*

John by realising “it wasn’t me” framed the diagnosis as something separate to himself, which he can perhaps purge or at the least exert some control over. This experience of diagnosis offering hope that they could do something different, was also shared by Craig, Mark, Bill and Nick.

*Puts things into a box, ready to be processed if you like...don't want to hear it and once you hear it, it does give you some clarity, all the barriers are down, you know, you're not worrying about the stigma so much anymore (Nick)*

Nick describes diagnosis as a process for sorting his experiences “into a box” in order to be dealt with, which also removes PTSD from being something internal within him. For Nick this may have helped reduce feelings of stigma, which others continued through using humour to discuss their difficulties. Nick’s use of the word “clarity” is apt, given the out of control, chaotic and lonely feelings most participants recalled prior to treatment.

The diagnosis of PTSD also appeared to normalise people’s experiences as it gave them an explanation of what had caused their problems and realising they were not suffering alone. Four participants explicitly stated they had been troubled by specific trauma memories and for them it was useful to gain a new understanding of their experiences through therapy.

*It was like someone opening the blinds and this new thing, seeing it for the first time ...because I have never ever seen it in the 20 years since it happened ...20 years down the line, I was still, I had ingrained this thought in my mind, and then she gave me another way of looking at it (John)*

The relief from discovering what had caused their problems was a longer and more complex process for people who could not identify a specific traumatic event. Although Bill could not recall one event which was particularly traumatic, throughout his career he had been exposed to numerous, chronic stressors.

*Whilst a lot of people you know might have had two or three individual very stressful experiences, people getting injured and that sort of shock, I didn't have that but I had a lower level thing which was repeated a hell of a lot more. And to a certain extent, probably more brain-washing (Bill)*

Because the events Bill had experienced did not typically fit within DSM-V (APA, 2013) criteria for traumatic events, he had previously struggled to access services which had left him feeling invalidated. Other participants appeared to make sense of how veterans might have symptoms or difficulties associated with PTSD, without a specific traumatic event, through the stressors and strains of training and operational tours:

*PTSD just can come from going through the whole process of becoming soldier... this whole militarisation of your mind (Mark)*

Mark and others referred to how powerful it was for them to be told by professionals that feeling distressed after difficult events is normal, which is contrary to stigmatised discourses they had previously been told that it was only the “weak” who would be effected. The stigma of having a mental health condition may have contributed to half of participants referring to PTSD as both a mental and physical condition, which may have served to distance their own experiences from that of madness:

*It doesn't matter what mental health condition is some people do look at you in a different way ... you know...but I tried to explain that it's a mental and physical ... mental and a physical thing. (Dave).*

Of all the participants Dave appeared most uneasy with having a PTSD diagnosis, which he felt left him “branded”. By emphasising that PTSD is a “physical thing” too, Dave is reconstructing PTSD as not purely a mental health condition which may make it more socially acceptable. However the “physical” symptoms of night sweats and hearts palpitations were some of the most troubling symptoms and probably exacerbating their distress:

*I was really worried there was something physically wrong with me, like night sweats... and when I found out they were because I perhaps dreaming or thinking about the issue, it made me feel a whole lot better, immediately knowing it was something normal, really, I wasn't weird. (John).*

These accounts not only suggest discomfort with mental health problems in veterans, but also the complexity and breadth of difficulties associated with PTSD which can be challenging for people to make sense of.

### 3.2. From layman's knowledge about PTSD to the technical ins and outs

From receiving their diagnosis and throughout their treatment programme, participants reported how they continued to make sense of their difficulties through learning more about the diagnosis. All participants recalled hearing of PTSD prior to diagnosis, but differed in their knowledge and how much military associations of cowardice and being “shot at dawn”<sup>6</sup> weighed upon them. Gathering a more detailed understanding of PTSD appears to have laid the foundations for them learning more about themselves, their experiences and how they might cope in the future.

#### 3.2.1. The “shot at dawn associations”

Whilst many participants agreed it was a relief to receive the diagnosis, four participants explicitly spoke about the military's long and complex relationship with mental health. Historical associations of shell-shock being linked to cowardice, weakness of the mind and shirking duty appeared to influence veterans in their making sense of the diagnosis. Craig repeatedly commented on his experiences of the army's stigmatising attitudes to mental health, which was commented on in most interviews. Craig discussed historical associations of combat stress which he felt were still relevant today:

*Cowardice in face of the enemy, you know – once a soldier, always a soldier. You know you are trained to do that job, so you go away and do that job. You don't think you are going to be affected by it (Craig)*

Craig constructs the work of a soldier to “always” be task driven and focused, prioritising their duty whatever the potential dangers. He states that one is “always a soldier”, which affirms his military identity and how he may still see those traits in himself even as a veteran. By using the word “job” he implies something banal or routine and minimises the potentially traumatic and stressful experiences soldiers may have. He also asserts that people tend to feel confident it will not be them who are diagnosed with it, which was reiterated by other interviewees. Bill discussed how diagnosis could serve to shatter people's perception of themselves as strong, which may make adjusting and accepting the diagnosis more challenging.

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<sup>6</sup> Reference to the First World War when soldiers with what in modern times would likely be recognised as PTSD like symptoms being “shot at dawn” for cowardice.

*Even though everything fits, it's difficult to believe you personally have PTSD, you feel you are stronger than that and you shouldn't have it (Bill).*

Bill implies in his account that the “strong” are not supposed to get PTSD and mental illness being a prerogative of the weak and cowardly was further exemplified in Mark’s account of being in the army:

*There's always the dark humour to cover up anything personal you know, I don't remember anyone ever speaking about mental health...[break]... I vaguely remember some lad saying he couldn't go because he had PTSD and we sort of took the mickey out of him, not to his face, but when we were in the mess we would say "oh he's a coward" and all that sort of thing (Mark).*

Mark illustrates how people with PTSD were deemed as weak and then further maligned through humour; this served to separate those with PTSD from the dominant group of “lads”, who performed hegemonic masculinity through being strong, tough and light-hearted. Feeling part of a team of lads, not wanting to disappoint them and risk denigration of being one of the weak, was another motivator for not sharing difficulties in the military:

*"Think it's primarily a male environment. You know, you're a team, you've got this feeling you know, if you pull out for any given reason you're sort of letting the other guys down. And there's also, you know there's very little sympathy in the army, at least during my time" (Mark)*

Participants shared how humour and the “light hearted military way” was an effective method of preventing discussions which may lead to expressions of vulnerability. Mark and other participants who identified as an older generation serving from the 1980s until the early 2000s, speculated whether attitudes towards mental health had since changed due to cultural shifts and introduction of TRiM. However Craig who was diagnosed in 2004, gave a relatively recent example of the lack of knowledge and acceptance of PTSD at a senior and structural level, which is likely to be maintaining and reinforcing attitudes throughout the military:

*They diagnosed me, but the army wouldn't recognise it, yeah. It was again you know the whole stigma around it, you know, the whole there's nothing wrong with you carry on soldiering, you're just tired. (Craig)*

Craig repeatedly mentions that his problems were previously minimised and ignored when he was in the military. Craig has been involved with other veteran charities, and alluded to a hierarchy of those with physical injuries receiving

more empathy and support. Whilst some may perceive physical wounds as a noble sacrifice, being mentally scarred from battle has long been associated with shame.

*But really it's an injury from the battlefield combat stress, where else are you going to get it from, not going to be in a supermarket shopping? (Craig)*

Craig in this excerpt appears to equate his difficulties with physical injuries which others may have from conflict and describing it as “combat stress”, re-asserts his military identity and distinguishes himself from the “PTSD” that civilians may experience. For others such as Tom, the historical perspectives of combat stress weighed less heavily and he appeared to make sense of his difficulties within a framework that everyone’s life contains suffering:

*It doesn't matter if you were bitten by a cat when you were 5 or you know you're in combat, it all leaves you with scars doesn't it? (Tom).*

Whilst the importance of historical context to PTSD differed between participants, all agreed on the barriers to help seeking and the bravery it requires to admit they needed help:

*It takes balls of steel to stand up and admit to it (Craig).*

In this excerpt Craig appears to be reclaiming sharing difficulties as not weakness, but something which requires a masculine strength, emphasised by the words “balls” and “steel”.

### 3.2.2. You have to surrender and go with it

Although most participants spoke of their relief at receiving a PTSD diagnosis, accepting the diagnosis and how it may fit for them was a process. Some participants spoke of initially wrestling with being in “denial” and feelings of shame, but in many accounts acceptance was cited as an important first step to coping. Most participants spoke of how having an open attitude to treatment and listening to what others suggested was key in their recovery, but as Tom described this could be challenging in itself:

*You have to surrender and go with it at Combat Stress (Tom)*

His usage of the word “surrender” which is an action of great humiliation in combat, demonstrates how difficult it felt to acknowledge difficulty and accept

help. Similarly James identified his struggle to accept difficulties because as a man he should be too strong and tough to experience problems.

*“The whole acceptance piece of... you know, yeah I’ve got PTSD or yes I’ve got something wrong, it was erm... that ignoring it and hoping it would go away, that all blokes do you know” (James).*

Whereas for Craig, his understanding of why it was so challenging for him to accept his difficulties was understood from a different lens of his soldier identity:

*I have had to admit that I have got it, secondly I have had to admit to the fact I was injured in combat which is something no soldier wants to admit to (Craig).*

Here Craig compares his PTSD as being in some way similar to that of being physically injured in combat, suggesting both carry shame perhaps because of injuries confronting people with their vulnerability. He also appears to view suffering from mental distress as additionally difficult, as you need to “admit” to it. Craig continues to explore this later in his interview when talking about an interaction he had with a veteran who had been shot in the face during service:

*“He looked at me and said “I don’t know how you get up every morning”. I said “what do you mean?” he said, “I can see my injuries but you can’t see you yours and that’s soul destroying” and I said “it is in a way, cos you’re fighting another battle” (Craig).*

Craig’s other “battle” may be to cope and adjust to living with his invisible injuries, or may allude to the battle he faces in having his difficulties recognised by others. Alternatively he may be emphasising his strength by suggesting it’s additionally hard to be fighting a mental health problem than a physical injury. Whilst other interviewees did not speak so explicitly, three participants mentioned feeling unworthy of help, or worried treatment was wasting tax payers’ money which distracted them initially during treatment:

*You feel guilty for being there...[break]... I bet this is costing someone a lot of money (Nick)*

Three participants reported that therapy as being useful for their recovery, through helping them to process past trauma memories.

*It was like someone opening the blinds and this new thing, seeing it for the first time ... because I have never ever seen it in the 20 years since it happened ... 20 years down the line, I was still, I had ingrained this thought in my mind, and then she gave me another way of looking at it (John).*



John continues on to say that therapy with a clinician whom he liked, respected and felt understood by, freed him from the traumatic memory he had been stuck in for many years. Both John and Simon reported how through therapy they had constructed a coherent narrative of what had been fragmented and torturous memories which could be “filed away”:

*Being able to have that explained to me, the traumatic incident was important ...but everything else was not important, everything else didn't matter until I got home... and how I got home is immaterial, really, so erm that was the biggest ...biggest thing to get filed away (Simon)*

All participants except for one, spoke of how they had noticed some other members of their cohort had done less well in treatment. They made sense of this as being because they had not accepted the diagnosis was relevant to them, which Bill had found so important in his recovery:

*I think it's extremely useful, and as soon as you get it and believe it yourself I think the sooner you get to the stage where you can start coping with it [hmm mm] erm, because think whilst you are still fighting with that diagnosis, you're not really listening to the coping strategies....floundering in the dark (Bill).*

James also identified accepting difficulties as key to him coping with his PTSD and his current well-being:

*I've got more of an acceptance, opposed to having a recovery. So I've accepted that I've got something wrong with me and I've accepted that I've needed to make changes to deal with that (James).*

For James, recovery was not a word in itself that was especially meaningful and instead accepting his difficulties and investing in trying to cope with them was the key.

### **3.3. A changing relationship with self, the world and others**

All interviewees reflected on a changing relationship with themselves, others and the military following diagnosis and treatment for PTSD. All participants were notably struck by the impact that meeting other veterans and sharing their experiences had on them. They all spoke of how this had cemented feelings of not being alone in their suffering, which were highly valued. However being amongst veterans also brought up reflections about their identity as a veteran and how they related to both civilians and the armed forces. Despite this, all participants spoke of how much they valued the on-going support and friendship of other veterans and how integral this was in their recovery process.

The support of family and friends back home was cited by all but one participant as important for their coping with PTSD and most noticed a positive change in their relationships following treatment. Some participants reflected on how they felt another important aspect of their treatment had been developing what Tom termed, a “relationship with me”.

### 3.3.1. No longer suffering alone

All participants spoke positively about meeting other veterans who had been through similar experiences, which appeared to reduce the stigma and shame associated with a PTSD diagnosis and provide a valuable support network.

*Meeting people and going “Jesus Christ, I do that, yeah, oh I do that as well!” and that really really puts into perspective erm... kind of... erm... kind of... yeah OK it’s not just me, it’s actually a thing (James).*

James described how meeting veterans helped him gain a sense of perspective, that his difficulties were not unique to him but as if an external “thing”. Making sense of difficulties as separate to him, may have helped him accept the diagnosis more and feel more empowered to act. Four other participants explicitly echoed James’ experiences of noting similarities in others to their own experiences:

*They’re just like carbon copies of yourself (Dave)*

For Dave this may have felt especially powerful, as he shared feeling unsupported and his difficulties had been disbelieved by his family and NHS professionals. For other participants engaging with other veterans appeared to be a stepping stone to being increasingly sociable once they returned home, after feeling cut off from others or self-imposed isolation for many years. Two participants noted that it was not necessarily group therapy or explicitly sharing experiences that supported them with understanding and coping with their PTSD, but simply spending time with similar people.

*I think a lot of the therapy ... you know...is just being in that environment with those people... even out of all those group sessions that you do, just at mealtimes or in the evening sitting in the telly room watching TV with him or whatever... (Simon).*

Even Bill, who in some ways had not felt the diagnosis fitted for him, appeared to find the similarities he had with other veterans out-weighted these differences:

*I think it's mainly knowledge, it's er... it's the fact that...I'm not the only person that's got this problem [...] I know they have had the same sort of problems, they are still having the same sort of problems makes somehow my problems more manageable or more understandable (Bill).*

Meeting others gave people hope they might overcome difficulties, but also a sense of familiarity through discovering shared personality characteristics and values (e.g. black humour, practical approach to life), as some had felt lacking in their civilian contexts.

*That sort of team spirit, you know erm... being ex-army that thing once you start something you're never going to leave it, you're going to do it to the best of your ability. And erm, being around other veterans was massively important for me (Nick).*

Feeling part of a team appeared important for many participants, as they shared experiences of feeling isolated prior to treatment. Even those with friends and family had struggled to talk about their problems, and it appeared meeting other veterans ultimately supported the process of talking about their difficulties and beginning to understand them which was immensely useful. Meeting veterans with other shared life experiences beyond the military and their traumas, was even noted as a turning point in their mood and sense of hopefulness:

*I met two guys who had all been in prison, it was er, it was strangely a relief, you know to meet guys. And that's when I started to feel slightly happier you know (Mark)*

For many participants this sense of connection and mutual support had extended beyond treatment to this interview, with all participants reflecting on the friendships they had made at Combat Stress with other veterans and how integral they believed this was to their continued coping with PTSD:

*It's a text here or there, or a call when someone's feeling down from my side or their side, you know. Erm, that's been really good, I made some close friends there (Nick).*

Like Nick, four other interviewees explicitly spoke of how helping and supporting others positively supported them in their recovery too, by seemingly providing a sense of connection with others and increasing their sense of self-worth.

### 3.3.2. My evolving relationship with me

Completing treatment and returning home prompted self-reflection in many participants about their identity. For a couple of participants treatment appeared

to have supported them to re-claim their old selves which were lost in suffering, for others it was about starting afresh. For some interviewees' treatment appeared to not just be about coming to terms with trauma, but reflecting on their entire lives.

Some participants described how treatment had made them aware of how much their personality had changed over the years, which for Craig was a shock accompanied by a physical reaction:

*I had to walk out as it made me physically sick, realising that I had been like that for such a long time and actually thinking Jesus Christ, what the hell? Where have I been? What has been going on? (Craig).*

Gaining more self-awareness and being more in touch with emotions was an important outcome from treatment for many participants. Emotions which they had perhaps felt it was previously too dangerous, or unacceptable to share before due to the masculine norms within the military:

*I'm just really happy, just really happy. And I can also feel really sorry for me, which I could never do before, I can feel sorry for that guy (Mark).*

Mark's switch to referring to himself in the third person, may indicate how he separates who he is now, to who he was prior to treatment as distinct identities. Mark, John, James and Nick all refer to embodying different identities as a military servicemen, sufferer and veteran, which may serve to reduce discomfort from any of their contradictory beliefs or behaviours during their lives:

*I'm a human. I can sort of be who I always was before I joined the army, I was quite creative, I was a bit of a hippy if I'm honest and I've sort of got that back (Mark).*

Here Mark describes his military self as almost inhuman, but now through resuming his creativity and connections to others he has been "re-humanised", after years of having his mind distorted and "militarised" within the army. Craig also speaks of how his military experiences profoundly changed him:

*I was drinking, I wasn't me, I wasn't the bloke who went to Iraq...I came back something completely different (Craig).*

It appeared gaining a new self-awareness was possible through meeting veterans and psychoeducation about PTSD, which supported veterans in understanding their difficult behaviours and emotions and what they could do to over-come them:

*I think I'm more positive and confident in myself erm... there's still a little bit of a challenge, I'm still not the most sociable of people, there's a little bit of a default setting of wanting to isolate [...] do feel the old Tom coming back (Tom).*

Tom appears able to now recognise the progress he has made in becoming his old self again, but also notice traits such as introversion which he feels are incompatible with his core sense of self. Whilst he and Nick appear to view changes as internal, James takes a different approach and sees any undesirable behaviours as part of his PTSD which he needs to act to discard:

*Sometimes I'll do something and go "right well that was PTSD". Ok, let's cut that out. It's actually, it's not an excuse, but it's a...identification if that makes sense that I'm doing certain things because, part of brain is doing this and that's really helping (James).*

Both approaches share an enhanced awareness of the self, but also a sense of power to make changes in how they act, behave, feel and appear in the world. The challenges of adjusting back home following treatment and continuing to reflect on themselves and their lives without the immediate support of therapists and fellow veterans was explored by Nick, Bill and James:

*There's an identity stage, and it's really up and down but for me I, I almost need a bit of a reminder of what I am suffering with and that keeps me on the straight and narrow to be honest. It would be ignorant of me just to try and go back into er... normal life as it were (Nick).*

Other participants spoke in other ways about how they were negotiating identity and roles in the lives, which for Bill was that he would have to retire due his poor sleep meaning he is easily fatigued.

### 3.3.3. A squaddie in civvy street

Negotiating a new or reclaimed identity following a PTSD diagnosis appeared to also be linked to how participants appraised their military experiences and settled into civilian life. Some participants spoke of struggling to adjust to civilian norms of humour, language and etiquette, as well as understanding how to navigate services.

Five participants expressing frustration at what they felt was ignorance of NHS professionals about PTSD, which had had the practical implication in their recovery of delaying appropriate assessment and treatment, but also left participants increasingly frustrated and isolated.

*The [GP] referred me to the community mental health scheme and erm... they were really unhelpful [...] Because I wasn't in the best place at the time, I got relatively frustrated with it and in the end just turned round and said I'm really sorry I can't talk to you, this isn't working, it's making me worse (James).*

For all participants it made an enormous difference to meet professionals who were experienced with working with veterans at Combat Stress. As James recalled from coming to Combat Stress:

*It was nice to actually find somebody that understood the way I was thinking and how to relate to it (James).*

Another aspect of treatment veterans signalled as important was by engaging with other veterans and speaking about their military experiences, was making sense of their military career and their identity as a veteran. Three participants had previously cut off ties with former colleagues and avoided anything to do with the military, as Mark recalls:

*"I couldn't get away quick enough [...] I never spoke to anyone in the army, never spoke to any of my friends" (Mark).*

For most veterans this appeared due to wanting to create a safe distance away from the military which had caused them uncontrollable pain and avoiding it seemed the most effective survival strategy.

Overall veterans were positive in their experiences at Combat Stress, but returning home for some participants was difficult due to uncertainty about jobs and continued experiences of stigma from others. Dave described how he almost felt like he was back to square one when speaking to his GP, who did not know much about PTSD:

*"When I go ... and talk to my GP they don't really know about it so you're trying to explain to them" (Dave).*

For some participants talking about coming home from treatment appeared to lead to reflections of how they had coped previously with transitioning from being in the military to civilian. Throughout his interview Craig made reference to how challenging he initially found it to integrate as a civilian, which may be due to his distress and feelings of suicide, but he also described challenges he faced in adapting to civilian humour, etiquettes and language. For Craig, agreeing to attend treatment at Combat Stress was not only about unresolved trauma, but a realisation he had not been adjusted well to civilian life.

*This is my civilian life basic training (Craig).*

Others also spoke of difficulties adjusting to life outside the military with its different rules and expectations about behaviour. Mark explained he used to tell people he was ex-army as a pre-emptive excuse in case he appeared unsociable, aggressive or odd. He also struggled to find work, which is likely to be challenging if he experienced internalised masculine norms of men as providers. Struggling to find a role in civilian life is likely to have further alienated some of these veterans from others and isolated them in their difficulties.

After treatment integrating into civilian life and finding meaningful work or a role was still challenging for some participants and causing them continued distress. For example, Simon had lost his job due to having time off for treatment and Bill had been told to retire due to his fatigue from PTSD combined with his age. Both Bill and Simon echoed Mark's description of how difficult it was to adjust to a loss of status from no longer working, along with a sense of anger at their opportunity to work being stolen from them by PTSD.

*I'm not going to work again. Now that took a lot of accepting by me... because of the amount of insomnia I've got, the fatigue that I've got, and to a certain extent my age (Bill).*

Simon expressed his anger by explaining he feels he is part of a "forgotten generation" of servicemen and that he has not got the support he deserves for all that he has suffered for his country. Feeling undervalued by society for him and other veterans appeared to be contributing to isolation and distress.

### **3.4. The road to more recovery and less suffering**

All but one of the participants regarded recovery as a life-long process and recalled professionals during treatment telling them it was incurable.

*You don't recover; you learn to cope with it. Your symptoms might erm... they might, diminish in size or in the effect they have on you, but I don't think they ever go away and several psychiatrists have said to me you won't actually recover from PTSD (Bill).*

Most participants believed like Bill they would always have PTSD related difficulties, but activities such as remaining in contact with other veterans from Combat Stress, abstaining from alcohol, keeping fit and engaging in meaningful activities would help them cope. Nearly all interviewees described recovery for

them being a process of continually managing their difficulties, with only one participant foreseeing a time when he would be “recovered”. Therefore for the remainder of this thesis recovery will be used to denote a life-long process of accepting difficulties and learning to cope with them.

Most participants took an active approach and stated it was down to them to continue what they had learned during treatment. Whilst many advocated this process of recovery and coping as something which would require strength of character and determination, the importance of acceptance and support from loved ones was emphasised – particularly by those who had experienced it. For those who did not, the connection with veterans they had kept in touch with from Combat Stress and other military organisations appeared all the more valuable.

#### 3.4.1. You’re always going to have your demons

Four participants spoke of an enormous transformation since their diagnosis, reporting feeling more positively about themselves, changes in their relationships and their mood.

*It’s just 100 things. Nearly everything, nearly everything’s changed (Mark).*

Mark repeatedly mentions feeling happiness and joy in his interview, which appears to not only be related to a lessening of his PTSD symptoms, but also through finding a meaningful job he enjoys and reconnecting with his partner and family through them sharing with them about all he has been through.

The other five participants spoke more cautiously. Whilst they had noticed that learning coping strategies had enabled them to exert more control over their emotions, they described how hard it was to persevere with lifestyle changes. Dave described still experiencing difficulties with his mood and a disconnection from others (but not veterans) since treatment:

*It’s difficult because I have good days and I have bad day days, I have days when nothing goes right or nothing feels like it goes right... you’re cross and angry at everyone all the time ... (Dave).*

Other participants shared Dave’s experience since leaving Combat Stress:

*Some days I feel that I’m completely in control and... I’m doing really well and things are great and you know, that nothing can touch me. I still have low days,*



*you know, as everybody does you know, I mean just life innit, everybody has low days (James)*

Whilst James experience is similar to Dave's, he additionally appears to have made sense of low mood and frustration as normal, which may reduce self-stigma. Whilst Dave appears to feel alone, James seems less encumbered by stigma by making sense of his difficulties as part of the fabric of "normal" life. It is possible these perspectives may be reinforced by their contexts; James has a supportive partner and is a paramedic who has found colleagues generally supportive and understanding, whereas Dave is a policeman which arguably is traditionally masculine profession where emotions may be less acknowledged or tolerated.

Like James, John also took a normalised approach to the word recovery and appeared hopeful about coping with challenges in the future:

*I mean you're recovering all your life, cause there's always going to be a knock back. But it is accepting it is a knock back and getting over it ... and carrying on. It's not a hurdle, it's a little gate and I'll open it and go right through (John).*

Many interviewees recognised difficult days would still lie ahead, but reflected since treatment they had more confidence in their ability to cope. Whilst Bill reported not observing any improvement in his symptoms associated with PTSD since treatment, he still greatly valued treatment for giving him a greater understanding which may have supported him in feeling more empowered to act to help himself.

*I don't think my PTSD has got any better, but I know what to expect from it (Bill).*

James also reflects on how he has perhaps more hopefulness for the future now, since being able to identify his difficulties as PTSD:

*It's also a really nice feeling to say OK I've got PTSD and I'm doing alright, so... there is life after PTSD if that makes sense, that would be my lesson (James).*

Whilst he stops short of saying he has recovered, James suggests a sense of hopefulness for the future. Tom was the only participant to consider himself tentatively "recovered" from PTSD and like James advocated a normalised perspective that everybody faces challenges in their "quality of life":

*I like the idea of it being kind of...yeah you know, you've been through that it's fixed, let's move on you know. So yeah, if I was going to say anything... even*

*though it is probably on-going, I think everyone's quality of life is on-going in one way another (Tom)*

Not only does he normalise his suffering, but he also suggests the difficulty of sometimes differentiating “PTSD” difficulties from “real life”. For example, Simon had faced a number of setbacks in his housing and job-seeking which had left him feeling frustrated and let down by systems which he hoped would support him and resulted in low mood, and was living this assertion of life throwing continual challenges at people.

*I can cope with PTSD... but its everyday life I am having trouble with at the moment (Simon).*

However, Simon states throughout his interview that he now feels better able to cope with his troubling memories and short fuse, through the use of Mindfulness and other strategies he had learned at Combat Stress. Simon is critical of the detrimental impact of cuts to services which have lessened his opportunities to get a job and protect him from homelessness. Whilst Simon was full of praise for Combat Stress and psychological therapies appear to have been useful for him, he expressed an understandable resentment given the mental and physical suffering he has endured since leaving the army.

#### 3.4.2. Taking on PTSD

All participants spoke of PTSD being something which to a certain extent had to be tackled alone, which required significant personal motivation.

*I'm quite a practical person and I know if there's something wrong in my engine, in my car I'll take it to a garage and they'll fix it. And that's how I tried to think about this is that... OK you're a bit broken, this is what's wrong with you, let's get it fixed (Tom).*

Upon learning about the diagnosis and getting an “answer”, many participants recalled firstly wanting to know what they could do and this active approach appeared to remain throughout treatment and beyond:

*Recovery for me – is...erm...an ongoing thing and it's up to me to do it (John).*

During treatment at Combat Stress participants recalled strategies they had learned to help them regulate their emotions and reduce rumination, which most had particularly struggled with. These included practising Mindfulness exercises and also cognitive therapy to help them explore and challenge difficult thoughts.

Such an approach appeared to fit well with many participants voiced preference for technical and concrete methods in which to both understand and “fix” what the difficulties they had. Nearly all participants recalled at least one of these different strategies as helpful during interviews.

*I have ways to deal with them now [...] You know, I take a breath ... think about it, don't let it become all encompassing. Just try... try and let it remain the small problem it is and not cascade, rollercoaster it into something huge it doesn't need to be (John).*

*I quite enjoy the mindfulness...I try to do that when I walk my dogs, you know about mindful walking...and also a yoga group...I found that very relaxing... because your mind racing all the time with PTSD (Dave).*

*Their coping strategies and the relaxation techniques and the Mindfulness is... erm... helps a lot really (Simon).*

Psychological therapies such as Mindfulness appeared to support many of the participants with rumination by focusing on the present. Another participant recalled discovering tools to challenge difficult thoughts as useful, but changing past habits of rumination, isolation and for some veterans drinking alcohol, was difficult:

*I've been in this rut for 15 years and it's like almost trying to walk again, like trying to walk in the opposite direction you...you've done it for so long (Nick)*

All Participants acknowledged it was challenging to continue with using strategies and lifestyle changes they had embarked on since treatment. The support of other veterans, family and friends was highlighted as important to keeping momentum, along with the benefits that veterans observed for themselves:

*If I don't exercise I'm grumpy, if I do exercise I'm alright...it's given me a target, something to aim for (James).*

Many participants cited fitness as an important aspect of their current well-being, and had developed an understanding that exercise had positive benefits for their mood. Developing new interests and strategies to cope with PTSD led others to reflect on what they had been doing prior to diagnosis to cope which had been ineffective:

*My only real coping mechanism was sort of self-harm and isolation and all they've done, they basically replaced them with you know, things like mindfulness, meditation you know... keeping an eye on my fitness (Mark).*

Not only did exercise or creative pursuits appear to distract interviewees from difficult thoughts or emotions, they also described feelings of enjoyment and pride which appeared to be in stark contrast to the isolation and shame of life before:

*I found oil painting, people love them (John)*

And he continues to explain how painting has helped him:

*I've found whenever, when I'm painting if my mind started to wonder in a bad way you could easily just say "oh I think I will put blue on" it's a way of... you can keep your mind occupied, really really easily by being creative (John).*

Keeping minds their minds from wandering and avoiding rumination was cited by many participants as a continual battle. However these strategies appeared to support veterans with feeling more in control in their lives, which contrasts with the uncontrolled, "shit storm" of emotions they had found so disturbing prior to diagnosis.

#### 3.4.3. From Isolation to Reconnection

All participants reflected on how support, or the lack of it, from family, friends and colleagues impacted on how they felt about themselves and their diagnosis of PTSD. A complex relationship between social support and recovery emerged. Whilst every participant advocated for the support of other veterans as fundamental to recovery, they shared diverse experiences of support from other people.

*I mean obviously my wife's been very tolerant with me (Bill).*

Of the five participants with long-term partners, four of them stated their partners had encouraged them in seeking help and supported them since leaving treatment which they had found incredibly valuable. Three participants also expressed some amazement that their partners had stuck with them through all their difficulties. It appeared since treatment, some participants were able to reflect on how their distress had impacted upon their relationships with others, which served to strengthen their bond and appreciation for their partners since treatment:

*I mean Lucy would have been well within her rights [...] she could have cut me loose... it doesn't bear thinking about (Mark).*

Recognising how life might have been, seemed also to motivate some participants to continue applying strategies and what helps them cope with their difficulties:

*“Lots of support from family. It’s all brilliant and I want to repay them by not being such an arse” (John).*

Treatment not only supported participants to reflect on their relationships, but three participants also spoke of how they had felt empowered to share some of their difficult experiences with family, which helped alleviate feelings of isolation:

*it wasn’t easy erm ... talking it through with them, erm...erm... but I still feel... now a little bit guilty for telling them really. Erm... it’s changed our relationship immensely, erm but it has changed it for the good. Because they they...understand now, they understand what’s going on... I understand what I’m going through and can explain to them about symptoms and how the brain functions and how it doesn’t function at times (Simon).*

Gaining a sense of feeling understood by partners and family was supported by their attendance at a family’s day at Combat Stress. Two participants who were single and invited other family members, also cited this day as important component of their recovery process. It appeared giving the participants’ support systems psychoeducation about what they had going through increased their understanding and better equipped them for continuing to support veterans once they were home.

*She’s got a bit more of a tolerance for my “bits” shall we say, whereas beforehand it was “for god’s sake, snap out of it sort yourself out”....[break]... instead of being pissed off that I’m down, that subtle change of accepting and acknowledging it but erm.. yeah... the ... that side of it has very much helped as well (James)*

However Dave and Nick experienced stigmatised attitudes from their families and throughout their interviews emphasised how for them it was a diagnosis they would be coping with alone. However Nick described how much he had valued support from people outside of his family, including colleagues and a friend who was recovering from drug addiction:

*Everyone in my life, my friends and family know what I’ve gone through and... and er.. the ignorance and stigma of them doesn’t really bother me, if there was to be any more since coming out of combat stress (Nick).*

Dave had experienced stigmatised attitudes from his mother and a lack of understanding from his partner and friends, which appeared to be having a

negative impact on his ongoing recovery. Conversely other participants suggested that people being too understanding or attentive could be problematic, which James and John referred to as the “kiddy gloves” treatment.

*I call it the kiddy gloves treatment... I don't need it, I will tell you if there's something wrong...I'm still a big boy, I can still look after myself (James).*

In this excerpt James comments on how he feels people treating him differently and he internalises their concern or condescension as a threat to his masculinity; He asserts that just because he was diagnosed with PTSD, he is “still a big boy” and strong enough to look after himself. Similarly John states:

*I don't want anybody to treat me with kid gloves, or on eggshells, but I suppose they have been...(John).*

His usage of the word “eggshells” conjures images of his fragility, which contradicts the strong warrior and masculine identity he may have previously enacted. Furthermore these examples of stigma illustrate participants’ desire to not stand out, but be treated “like anyone else”.

However encouragement from friends and family about changes they had noticed in the participant since treatment, appeared to provide an incentive and boost to self-esteem which was greatly valued:

*Somebody you love and care about saying they can't believe the difference in you, that's brilliant isn't it? (Tom).*

Craig, like Tom, also experienced support and admiration from his father following treatment. Both of these participants did not have partners at the time of interview, but spoke of losing relationships due to their difficulties with PTSD. Since treatment like most of the other participants, they had noticed they wished to be more sociable and less isolated. Tom reflected on what PTSD had cost him, but also suggested a motivating factor for seeking help and staying on a recovery pathway was desiring a relationship in the future:

*Being sick of it and wanting and not wanting it anymore, that would be one thing, but I think I lost a lot. I lost a beautiful house, life, a wonderful partner and all that I lost and I think the...you know that, I think that may have been a good incentive, unless you deal with this, you'll never have anything again (Tom).*

Tom by reflecting on what he had lost, also suggests what he would hope to have again in his life and through meeting veterans, understanding more about

himself he has perhaps become unstuck and able to imagine a more hopeful future.

## CHAPTER FOUR: DISCUSSION

This study sought to explore veteran's experiences of recovery following treatment for a diagnosis of PTSD. The results suggested many participants viewed the word 'recovery' as inappropriate, ostensibly due to beliefs about PTSD being a life-long condition which they would have to actively cope with alone. If the word 'recovery' was used by participants, it was framed as a long term journey or process, which appeared to be dependent on them accepting there was a problem and taking action.

Participants in this study voiced being at various stages in their journey of coping with their difficulties. The majority had noticed improvements in their mood and relationships since before they accessed treatment and these changes appeared to begin with opening up to someone about their difficulties and the relief of receiving a diagnosis. The majority of participants appeared to reflect on having a diagnosis as a positive gateway to treatment and understanding more about themselves, gaining a coherent narrative of their difficulties and trauma, as well as learning what they could do to minimise PTSD's impact on their lives.

Whilst four veterans explicitly stated that therapy had supported them with recovery from a traumatic experience, for other veterans it appeared the therapeutic benefit was broader and more about understanding themselves and negotiating their identities from soldier to veteran. Finding meaningful employment and hobbies was noted by most veterans as useful to their well-being, and for those who struggled to find work or had been forced to retire this appeared to have a detrimental impact on their self-esteem. Similarly all participants alluded to stigma surrounding mental health difficulties and how this, along with discourses of masculinity declaring that men must be strong, stoic and not share problems (which were reinforced by their military career), impacted upon their continued journey from less suffering to more recovery.

### **4.1. Veterans' experience of recovery following treatment for PTSD.**

Four master themes emerged within this data including: the relief of being diagnosed with PTSD, gaining more knowledge of the "technical ins and outs"



about PTSD, noticing a changing relationship with themselves, others and the world and recovery being a journey that would continue for the rest of their lives.

#### 4.1.1. Overcoming fears of “opening-up” about their difficulties

For most participants seeking help and opening up about their difficulties was the beginning of their recovery process. This study echoed findings of Murphy et al., (2013), that veterans were often motivated to seek help once they had reached a crisis point and believed they may otherwise lose relationships, jobs or homes. For other people like Mark who had been in prison, there was little option but to accept help. Participants’ reluctance to seek help appeared to be related to the stigma surrounding mental health problems (e.g. meaning you are “weak” or “acting like a girl”), which is prevalent within military contexts.

These accounts conform with literature arguing that traits of self-reliance, emotional control and physical toughness (Higate, 2003; Burns & Mahalik, 2011) are highly valued within the military. As one participant commented (John), it is possible stoicism and “stiff upper lip”, also reflect wider traditional white- British values which MAF are particularly expected to perform.

Summerfield (2001) suggested these fêted characteristics can be traced back to World War Two, where there were prominent discourses of the British people’s “bull-dog” tenacity contributing to the war effort. These hegemonic masculine and cultural values appear to have contributed to psychological barriers for veterans in accepting that there was something wrong, due to beliefs they were “stronger” than that. However, most participants stated that accepting their difficulties was integral in their recovery process and were surprised by the healing power of opening up and talking about their difficulties.

In some way accepting their difficulties may have been facilitated by participants’ veteran status. Connell (1995, p131) theorised that renouncing a career may free men to also renounce its masculine practices and enact new identities. Indeed many participants reported that since treatment they were more emotionally expressive, which they perceived as a positive change. Thus participants’ veteran status may have contributed to them feeling able to explore their emotions, “surrender” to professional help and be more able to care for themselves.

#### 4.1.2. Suffering being validated as “real”

Participants discussed that an important aspect of recovery was challenging their preconceived ideas and beliefs about PTSD. A consensus across all but one of the interviews was that a PTSD diagnosis served a function of normalising their difficulties and providing reassurance their distress was “real” and not indicative of being mad or horrible as they had initially feared. For those who reported that they had experienced specific traumatic events, learning that their difficulties could be traced back to an event appeared to facilitate understanding and normalising processes. Summerfield (2001) argued that as a society by using the diagnosis of PTSD we pathologise mental distress. Whilst this and other literature critiquing PTSD as a diagnosis is immensely valuable and relevant to this work, within this research all but one participant found the diagnosis a validating and normalising experience, as it gave them a framework in which to make sense of their difficulties. Whilst there may be many reasons to account for why one veteran found the diagnosis unhelpful, notably he described feeling unsupported by friends and family which may have effected how he appraised being given the diagnosis.

Some participants’ described that initially struggling to accept their difficulties was not only due to PTSD’s association with weakness, but also because of prominent discourses that it is not a “real” diagnosis. This appeared to have been reinforced by widespread military attitudes towards PTSD, but also disparaging remarks three participants reported from their families. This appeared to be further complicated by subtle hierarchy in who deserves support, as one participant spoke of the invisible nature of mental health problems which makes acceptance and recovery more challenging. Ideas that physical health problems appear more acceptable than mental health difficulties within the military have been suggested within other literature (e.g. Rona, et al., 2004).

It is possible professional debates surrounding PTSD and what constitutes a traumatic event (e.g. Brewin, 2011), in some cases may make it more difficult for veterans like Bill to access treatment, which may serve to exacerbate their distress and isolation. This was echoed by other participants who during interviews appeared to have made sense of problems as being reflective of

being in the military, rather than a specific event per se. In America Frueh, Elhai, Grubach et al., (2005) found that some veterans without combat exposure were accessing treatment for PTSD, which they concluded was professionals making false positives and related to insurance claims.

However, this study's data may also add to arguments that military related traumas are especially complex (e.g. Lerner & Blow, 2011), which current psychiatric models may inadequately capture. More generally, critics such as Summerfield (2001) suggest that the diagnosis of PTSD is reductionist and lacks specificity to capture the complex psychological sequelae following a traumatic experience. Arguably Herman's (2001) theory of complex PTSD, characterised by experiencing many uncontrollable events which a person perceives as threatening to their psychological or physical integrity, which can have lasting impact on people's identity and relationships may be more fitting for many of the participants within this study. During interviews all but one participant reflected on positive changes they had noticed in their relationships and identity (e.g. self-awareness and improved self-esteem) since treatment.

#### 4.1.3. "I am not alone"

Trauma can shatter people's sense of self (Herman, 2001) and participants described reconstructing, or recreating their identity as part of their recovery process. For many participants their time of suffering prior to diagnosis was a period when they were acting in a way which did not fit with who they felt they were; therapy and re-connecting with other veterans and their families appeared to have a powerful impact on them re-developing a sense of self. Going away for treatment and living with similar people, engaging in therapy with an empathetic therapist may be considered through the lens of Maslow's (1943) hierarchy of needs. Once veterans had their fundamental physiological and safety needs reasonably well met, then reconnection with their own emotional and psychological needs may have been possible.

The process by which participants began to reconstruct a sense of self, appeared to occur in the context of connecting with other veterans in treatment. Herman (2001, p70) argues "sharing the traumatic experience with others is a precondition for the restitution of a sense of a meaningful world". Undeniably meeting other veterans had a powerful impact on all of the veterans in this

study. This offered a support network to keep them going when life was challenging, share support strategies and crucially friendship when they most needed it. Herman (2001) described this as “commonality” and vital for recovery from trauma, as survivors’ connections with others serves to bolster their sense of identity.

In these accounts noticing similarities and shared experiences with others facilitated an understanding that what they were going through was not weird, or mad, but something normal which could be overcome. For all participants connecting with veterans during treatment appeared to be the first step in overcoming the alienation they had felt for so long on “civvy street”. Being reunited with a group of veterans with shared experiences was an incredibly powerful experience which gave them a sense of belonging. Whilst for some this intensified feelings of loneliness after treatment, keeping in contact with a few veterans from the course was supporting them through difficult times. It was striking within these accounts the positive impact that social support could have on recovery processes, which echoes literature (e.g. Bisson, 2009) citing the protective and healing influence social support can have for people.

Sharing experiences for some of the participants continued after treatment, as three of them discussed taking on public roles where they would be telling people about what they had gone through. For all participants narrating their experiences to me at interview may have continued the storying and sense making process.

#### 4.1.4. A veteran on “civvy street”

Teachman and Tedrow (2007) argue that military service has an impact on people’s life course trajectories and many participants reflected on processes of suffering and recovery in the context of their life-stage (e.g. their children’s ages, retirement). Some of them also spoke of different identities they had held as a servicemen, sufferer with PTSD to embodying the “coping veteran” most were at interview, who had to adjust to civilian way of life. For many it was difficult to remember a time before the military as they had joined up during adolescence or young adulthood, which is often regarded as critical period of identity development (e.g. Erikson, 1968). All participants once in the military would have become part of a cohesive unit (Braswell & Kushner, 2011), and

internalised group processes endorsing certain values, attitudes and behaviours (Atherton, 2009).

Upon leaving the military these participants may not only have been struggling with distress and fears of madness, but additional concerns such as a loss of status and responsibility, struggling to adjust to living back with their families and lack of interest and understanding from civilians of their military careers (Wolpert, 2000). All participants within this study spoke of these challenges as factors that had made coping with their PTSD more difficult in the past. At interview some participants expressed frustration about the ignorance they perceived in civilians as to the military way of life and injustice regarding how their sacrifices seemed forgotten. This may reflect Patel's (2003) assertion that PTSD depoliticises people's experiences, as it may leave veterans with a heightened feeling that they have something wrong with them, rather than questioning why some conflicts occur or are publically commemorated.

However other participants took a more positive view of having a diagnosis which for them was interweaved with their military career, as Craig called his treatment for PTSD his "civilian basic training". In this way part of recovery appeared to be about reconciling with their veteran status, which opened up opportunities for a "new me", such as Mark recalling that leaving the army has enabled him to reconnect with his "hippy" self. Mark's experience may capture Connell's (1995, p.131) theories relating to how renouncing a career can separate men from re-masculating practices and open up new opportunities for self-definition.

#### 4.1.5. Recovery as a life-long journey

Nearly all participants rejected recovery as a useful word to conceptualise their journey from distress to increased well-being. Participants stated that during treatment they had been told PTSD is incurable, which inevitably will have impacted on their beliefs surrounding their future after a PTSD diagnosis. It is possible during treatment participants were exposed to traditional psychiatric perspectives on PTSD which tend to conceptualise trauma responses in terms of illness, deficit and neurobiological dysfunction (Summerfield, 2001), compared to social based accounts of PTSD which may emphasise the opportunities for recovery, survivorship and personal growth.

Herman (2001) in her clinical work with survivors of trauma, suggested disempowerment and disconnection to be core features of psychological responses to trauma; these states appeared to be present in all accounts of veterans prior to diagnosis and treatment, as they recalled intense isolation and helplessness. All participants drew on salient aspects of what they had learned about PTSD that had been most helpful for their recovery. Some participants recalled how therapy had supported them to “file away” traumatic memories and received a plausible explanation for their difficulties (e.g. due to cognitive functioning or neural pathways), which could be thought of in terms of Ehlers and Clark’s (2000) Cognitive theory of PTSD (see section 1.3.4.3). However other participants appeared to make sense of their PTSD differently, seeing it as something which developed from being immersed in the military culture with its constant stressors and threats.

Gradually with the support of other veterans and a therapist, most participants reported since treatment being able to use psychological coping strategies to exert some control over their difficult emotions and behaviours. This is likely to reflect their engagement in CBT which is likely to have emphasised the participant taking an active role in therapy through mastering coping strategies (Westbrook, Kennerley & Kirk, 2007). Most participants recalled at least one strategy they had found useful and maintained it was down to them to ensure they continued their recovery progress. This individualised approach is not only indicative of the CBT therapies the veterans undertook, but also are reminiscent of hegemonic masculine values of being task driven and individual’s strength. Such values have been suggested as helpful in other studies (Caddick, Smith & Phoenix, 2015), which have warned against assuming all aspects of hegemonic masculinity may be problematic to positive health behaviours.

Since treatment some participants appeared to experience their problems (e.g. their “shit-storm of emotions”) related to PTSD as something separate to themselves, by talking of “PTSD days” or metaphors of PTSD being kept in a box which they could now choose to open. It is possible therapy supported participants to no longer perceive their negative experiences to be internal, persistent and global, which Peterson and Seligman (1984) argued can contribute to psychological distress as people feel powerless and unable to see how life could be different in the future. PTSD being understood as something

separate to the self, could also be reminiscent of Narrative Therapy (White & Epston, 1990) which posits that through externalising problems people can free themselves from the toxic and oppressive effects of problems.

Whilst experiences of post-traumatic growth (PTG: Tedeschi & Calhoun, 1996) are much discussed within PTSD literature surrounding recovery this was not the focus of this study. Some participants (Mark, John, Craig and James) in their accounts described improvements across relationships, a new appreciation for life, looking to the future and feeling more equipped to tackle difficulties which are similar to PTG. However none of the participants mentioned spirituality in their interviews. Interestingly participants whose experiences were in some way similar to PTG were those who voiced having strong social support, but more specific research into PTG would need to establish whether it is a meaningful concept for veterans.

#### **4.2. Implications for Clinical practice**

Some important considerations for clinicians working with veterans with a diagnosis of PTSD emerged from this study. This research reiterates findings from existent literature (e.g. Murphy et al., 2013) that people are reluctant to seek help for PTSD due to the stigma surrounding help-seeking and mental health difficulties. This suggests the importance of not only ensuring referral pathways to services are easy to navigate, but also continuing funding to develop projects such as TRiM to reduce stigma about mental health difficulties in the Armed Forces. Engaging ex-servicemen with a PTSD diagnosis in these initiatives may be beneficial, to ensure information is relevant and accessible for veterans. Given some of the participants in this study identified supporting others and sharing their experiences was important for their recovery, it is possible that such involvement echoes findings that working collectively to shape services can boost people's confidence, self-esteem and help develop new skills (Mental Health Foundation, 2003).

Helpful aspects of hegemonic masculinity about taking action on problems could be capitalised on, rather than simply warning of the dangers of not seeking help. Furthermore given this study's exploration of military masculinity

on recovery, clinicians could include within their assessment and formulation hypotheses surrounding veteran's beliefs about help-seeking, their identity as ex-military and also men and how these may be contributing to the person's difficulties and the therapeutic work.

Many of the veterans involved in this study reported experiences of finding mainstream NHS services (especially GPs and community mental health teams) uninformed about PTSD and they felt branded as hypochondriacs or malingerers. For some participants this seemed to have contributed to feelings of low self-esteem and that their distress was insignificant and unworthy of professional support. As Bill one of the participants in this study suggested, it may be useful if professionals during training were encouraged to take a more critical approach to PTSD as a diagnosis and consider the idiosyncrasies in how people's distress may manifest itself, through taking a more trans-diagnostic or formulation approach. However it is acknowledged that current national funding policies may make working in this way challenging for clinicians.

Despite the controversy surrounding PTSD as a psychiatric diagnosis, most participants appeared to find having the diagnosis helpful; providing it was explained clearly and in a way which was meaningful and validating of their symptoms and experiences. Many participants described beliefs that their current difficulties were not only the result of specific traumatic exposures, but a product of institutionalisation, gruelling training, repeated stressors and separation from the civilian world during their military career. This adds some support for Patel's (2003) assertions that clinicians run the risk of blaming the individual for their distress and reinforcing toxic socio-political agendas if they are politically neutral when working with trauma survivors; but given services are largely government funded, it is acknowledged attending to socio-political contexts of war and conflict may be a challenging ethical dilemma for clinicians.

Meeting other veterans and being away for six weeks in treatment appeared useful for most of the veterans interviewed in this study, with one even describing the "real" therapy as coming from simply being with other veterans. However, it is possible for some veterans this inpatient treatment model may bring back distressing memories of basic training and "being in the mob", which may be unhelpful for treatment. As some veterans reported feelings of isolation



increased after they left the comfort of the treatment centre, helping veterans to develop and maintain community-level support is evidently important. Whilst this is inevitably an expensive resource, Combat Stress should be supported to sustain its local treatment centres to maximise help for veterans in their communities. As finding work or navigating the benefit system is a key concern for many veterans, it is essential services take a holistic approach to their needs and signpost to relevant charities as required.

In this research most participants reported engaging in new activities with other veterans as being integral to their recovery and community level treatment models could be group based and be activity focused (e.g. cycling group). Whilst many participants highlighted the positive impact of support from friends and family, two discussed the toxic impact that stigma and intolerance from their family had on their recovery. Whilst clinicians may not always be able to work with the veterans' wider network, supporting the veteran with ways in which to navigate and challenge these perspectives (perhaps using social constructionist frameworks) may be useful.

Most participants cited either some CBT (e.g. cognitive restructuring or behavioural activation) or Mindfulness strategies (e.g. meditation practice or increased awareness of the present) they found useful from therapy. Although NICE guidance (2005) cites EMDR and CBT as best practice for "PTSD" treatment and whilst they may be very useful for some, they may have limitations when working with this client group. For example, developing a coherent narrative of the context to traumas and military experiences were cited frequently by participants as being important in their recovery. This appeared to occur both through psychoeducation materials about how military training and values can pave the way for PTSD, but also through a strong therapeutic relationship with their therapist who "understood" and they got on "famously with" during treatment. This may suggest "non-specific" therapeutic variables may have been instrumental to their recovery, which unfortunately can be challenging to evaluate in many of the outcome tools which Combat Stress and NHS services are under financial and political pressures to report.

### **4.3. Limitations**

IPA methodology was appropriate for the aims of this research and has resulted in rich accounts of nine veteran's experiences of recovery following treatment for PTSD. Given the idiographic nature of IPA, the themes and claims made about the results from this study cannot be generalised to all veterans' experiences. Whilst throughout the study I have sought to be transparent and reliable in my analysis of the data, the results are my interpretations and therefore it is possible another researcher may have highlighted alternative themes as more significant.

IPA requires homogeneity within participants. The participants in this study had varying lengths of military careers and as was outlined in the methodology section, little information was gathered about details of trauma exposures. Whilst this was not central to this research question, future investigations into recovery might be curious about people's appraisal of their traumatic experience and also the context in which they left the military. The participants being recruited from one treatment centre offers some homogeneity, but also means that their perspectives on recovery are likely to reflect this specific treatment centre and may not be representative of other veterans with PTSD treated elsewhere.

Participants volunteered for this study and this will have created some bias. Whilst it was explicitly stated to participants that the study hoped to gain a deeper understanding of recovery from perspectives of what could be going well or challenging, arguably volunteers were more likely to be people who felt more hopeful or optimistic about their recovery. However as participants did discuss their continued struggles, there was evidently some diversity across participants' accounts. Furthermore the significant distress many of the participants reported suffering before diagnosis, indicates this study's sample was not merely those who had mild experiences of distress or had suffered less.

Interviewing over the telephone possibly affected data in terms of rapport building, but I did not notice challenges establishing rapport with interviewees and some authors (e.g. Cachia & Milward, 2011) argue for the validity of IPA

interviews over telephones. Whilst some participants may have felt more comfortable speaking face to face, they all would have received telephone follow-up from their treatment and so it is likely that to a certain extent this would have felt familiar to them. Using the telephone was advantageous in that recruitment was unrestricted by location and it is possible some participants may have felt less self-conscious talking over the phone about personal experiences than being face-to-face. It is difficult to surmise how being a woman with no military experience affected conversations, considering one participant's (James) observation that women were easier to talk to. Interestingly the participant who I most struggled with to engage in conversation had experienced significant stigma from his female partner. Given few participants specifically mentioned their psychological treatment, I do not believe being a trainee clinical psychologist was a biasing factor – indeed one participant (Bill) was noticeably critical of psychology as a profession.

This study was cross-sectional and served as a “snap-shot” into how people made sense of their experiences at a particular moment in time. It is possible on a different day our conversations and the subsequent analyses would have been very different.

My previous experiences working with MAF and veterans and my social constructionist approach to mental health will have inevitably influenced my co-construction of participants' experiences. However I have strived to be as faithful as possible to validity guidelines on IPA research and engage in supervision to minimise these biases.

#### **4.4. Future Research**

Given the paucity of qualitative research into veterans' experiences there are many directions future research could take. In terms of recovery it would be interesting to interview people who did not complete treatment or a greater number of participants who were still struggling following treatment to find out what made recovery more difficult for them to inform future clinical practice.

Alternative qualitative methods could be employed to get a deeper understanding of recovery from PTSD. For example paper or video diaries may be a creative, but also valid way of recording participants' "in the moment" reflections about their life after receiving a PTSD diagnosis and embarking on treatment. A longitudinal design of diaries being collected may lead to interesting insights into people's recovery journey.

The bulk of military mental health research tends to focus on the white- British, heterosexual male majority, which unintentionally occurred in this study as only men who identified as such volunteered. Fewer researchers have investigated the experiences of women, servicemen and women from non-white ethnicities or those who identify as lesbian, gay or bisexual. Fewer female veterans have traditionally been diagnosed with PTSD due to their lesser prevalence within the military and for many years their exclusion from combat roles, and subsequently their experience of military and veteran life has not been the focus of much research. Future research could explore the experiences of both developing an identity within the services and how it is discarded upon exiting the military, with people from marginalised or minority identities within the military.

#### **4.5. Conclusion**

This study contributes to the knowledge base surrounding veteran's experience of recovery following a PTSD diagnosis and using IPA has meant rich accounts of veterans' experiences of recovery could be analysed. The results of this study offer insight into what factors may support people in their recovery and how clinicians can facilitate it, as well as suggesting potential areas for future research into veterans' experiences.

The majority of participants in this study reported recovery as making sense to them as a "journey", whereby they would continue learning to cope with their difficulties for the rest of their lives. This study affirms previous work that stigma surrounding mental health not only could dissuade people from accessing treatment, but also appeared to hinder recovery. Given how fundamental social support appeared to be within this study, these findings emphasise the importance of wider initiatives to normalise talking about distress and consider

ways in which hegemonic masculinity may be problematic, but also facilitate well-being. Gaining a coherent narrative of why their problems occurred, appeared to be the early steps towards recovery and constructing new beliefs about the self, others and the world around them. Also salient within this study was the journey of self-discovery many of these veterans were experiencing alongside their mental health difficulties, as they wrestled with their role and purpose in life having left the Armed Forces. Whilst these accounts illustrate the complexity of people's difficulties and the despair that can come along with this diagnosis, it also highlighted the hope that many felt for their lives:

*OK I've got PTSD and I'm doing alright, so... there is life after PTSD if that makes sense... that would be my lesson (James)*

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## APPENDICES

### Appendix 1: Search strategies for literature review.

An initial scoping literature search was conducted to identify relevant key papers on this topic area. The following key words were used and paired as shown below:

1. Veteran or army or military or armed forces or personnel
2. Limit 1 to English language
3. Limit 2 to human
4. Combat or stress or post-traumatic\* or posttraumatic or PTSD or trauma.
5. Limit 4 to English language
6. Limit 5 to human
7. Recovery or rehabilitation
8. Limit 8 to English language
9. Limit 8 to human
10. 3 + 6 + 9
11. Remove duplicates from 10.

These key words were searched in the following databases: Embase, PsychInfo (1806- present), PsychArticles and Ovid MEDLINE (1946 – Jul week 3 2015). This initial search on 27<sup>th</sup> July 2015 brought up 2533 articles, 84 of which were deemed relevant to this research. Most articles were discarded due to being Americentric, quantitative in design and/or they focused primarily on the prevalence of PTSD and not recovery.

Google scholar was used to retrieve papers which were either cited or were cited by these papers initially found through the above Ovid search, which were deemed to be of interest.

**Appendix 2:** Letter of ethical approval from the University of East London.

## **NOTICE OF ETHICS REVIEW DECISION**

### **For research involving human participants**

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

**SUPERVISOR:** Poul Rohleder

**REVIEWER:** Lara Frumkin

**STUDENT:** Philippa Hatton

**Title of proposed study:** exploring members of the uk armed forces experience of recovery following treatment for post-traumatic stress

**Course:** Professional Doctorate in Clinical Psychology

**DECISION** *(Delete as necessary):*

**\*APPROVED**

**APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

**APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

**NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

**Minor amendments required** *(for reviewer):*



**Major amendments required (for reviewer):**

**Confirmation of making the above minor amendments (for students):**

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (*Typed name to act as signature*):

Student number:

Date:

**ASSESSMENT OF RISK TO RESEACHER (for reviewer)**

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

☐

MEDIUM

☒

LOW

*Reviewer comments in relation to researcher risk (if any):*

**Reviewer** (*Typed name to act as signature*):      *Lara Frumkin*

**Date:** 8/5/15

*This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)*

**PLEASE NOTE:**

\*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

\*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: <http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

## **Appendix 3: The study's information sheet**

### **The Principal Investigator:**

Philippa Hatton

School of Psychology

Stratford Campus,

Water Lane, London E15 4LZ



University of East London  
School of Psychology  
Stratford Campus  
Water Lane, Stratford  
London, E15 4LZ

### **Consent to Participate in a Research Study**

#### **EXPLORING MEMBERS OF THE UK ARMED FORCES EXPERIENCE OF RECOVERY FOLLOWING TREATMENT FOR POST-TRAUMATIC STRESS**

Thank you for your interest in taking part in this study. Before you decide whether this is something you would like to do, please read through this letter which contains more detailed information about the project.

#### **What is the aim of this study?**

I am doing this research as part of my Clinical Doctorate degree at the University of East London. The aim of the research is to explore members of the UK Armed Forces' experiences following their treatment for posttraumatic stress disorder (PTSD). This research is interested in how it feels to receive a diagnosis of PTSD, be offered treatment and your ideas on what has helped or held you back in your recovery. If you decide to take part you might be asked things like "what was it like for you to receive a diagnosis of PTSD?" or "what does recovery mean to you?"

#### **What does taking part involve?**

I will be interviewing people over the telephone for around 45 minutes who have been a member of the armed forces and received treatment for a diagnosis of PTSD at Combat Stress in the last 2-4 months. It is important for you to be aware this study is neither evaluating the treatment you received, nor going to include questions which ask you directly about any trauma(s) you experienced.

There are no risks or dangers involved in taking part. However, it is possible you may feel upset if you talk about something you have found difficult. You are able to stop the interview at any time and everyone who takes part in the study will receive contact details of support organisations.

#### **What happens to the information from interviews?**

All interviews will be with me (Philippa) over the telephone. The interview will be recorded on a digital recorder and only I will listen to the recordings and type them into transcripts. To ensure confidentiality any names that are mentioned, including yours, and anything that would make you or anyone else identifiable will be changed in the transcript. This typed

transcript may be read by Poul Rohleder (my supervisor at the University of East London) or the examiners who assess my thesis. No one else will have access to the transcript. The audio file and transcript will be saved on a computer that is password protected. After the examination, the researcher will delete the audio recordings and the written transcript will be kept as a computer file for up to three years.

The finished research will form an academic thesis, but data from interviews may also be used to write articles to be published in academic journals, but all identifying information will have been removed. The final research will include a small number of quotes from interviews, but these will be carefully chosen to refer to general themes and also pseudonyms will be used to minimise any chance of you being identified.

#### **Are the interviews confidential?**

I am not informing Combat Stress, or any other individual or organisation, the names of people who are taking part in this study. I would only break confidentiality if you told me something which caused me to become worried about your safety, such as telling me you had thoughts of suicide or hurting yourself or others. If I think I may have to break confidentiality (e.g. telling Combat Stress I was worried or calling the emergency services), I would inform you of this first.

#### **Where will interviews take place?**

Interviews will take place over the telephone and at a time and place where you can be somewhere which is free of distractions and you will not be overheard. The researcher will also ensure she is somewhere quiet and will not be over heard during the interviews.

#### **Disclaimer**

You do not have to take part in this study and should not feel forced in any way. You are free to withdraw at any time and your data will be erased and not included in the write up. If you choose to withdraw you do not need to give a reason why. Not taking part or withdrawing from this study will have no impact on your relationship or future treatment with Combat Stress or any other mental health service.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please keep this invitation letter for your information. If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor [**Dr Poul Rohleder, School of Psychology, University of East London, Water Lane, London E15 4LZ. Tel: 020 8223 6674 . Email: P.A.Rohleder@uel.ac.uk**]

or Chair of the School of Psychology Research Ethics Sub-committee: **Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)**

Thank you in anticipation.

Kind regards

**Philippa Hatton**

**17/04/2015**

## Appendix 4: The study's consent form.

### The Principal Investigator:

Philippa Hatton

School of Psychology

Stratford Campus,

Water Lane

London E15 4LZ



University of East  
London  
School of  
Psychology  
Stratford Campus  
Water Lane,  
Stratford  
London, E15 4LZ

## Consent to Participate in a Research Study

### EXPLORING MEMBERS OF THE UK ARMED FORCES EXPERIENCE OF RECOVERY FOLLOWING TREATMENT FOR POST-TRAUMATIC STRESS

I have read the information letter relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions. I understand what is being proposed and the procedures in which I will be involved, and it has been explained to me what will happen to my data once the research study has been completed.

I understand that my involvement in this study and particular data from this research, will remain strictly confidential and only the researcher will have access to my identifying data. I understand the only exception to this is if I disclose something to the researcher (e.g. suicidality or risk to self or others) which causes the researcher to become concerned about mine or another person's safety. In this instance Combat Stress and/or the emergency services may be informed of my participation in the study.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

**Participant's Name (BLOCK CAPITALS)** .....

**Participant's Signature** .....

**Researcher's Name (BLOCK CAPITALS)** .....

**Researcher's Signature** .....

**Date:** .....

## Appendix 5: Semi-structured interview schedule

**Opening:** How are you? As a reminder you can withdraw. Any questions?

Before we begin some general questions about you:

Gender		What service	
Age		How many years	
Ethnicity		Year left services	
Marital status		How many deployments	
No. of children		Last deployment	
Are you employed			

1. When did you first receive your diagnosis of PTSD?
  - What was that like for you?
2. At the time, did you feel this diagnosis fitted your experience?
  - How about now?
  - Why?
3. What does the word “recovery” mean for you?
4. How might you describe recovery in terms of your diagnosis of PTSD?
  - Is it something you have experienced, or perhaps are experiencing right now? What was/is that like?
  - Do you feel you have control over your recovery?
5. If you compare life now, to how it was when you were first diagnosed with PTSD, do you notice any change?
  - **[IF SAY YES]:** In what way?

*[prompts]:* How you feel about yourself?

In what you are doing?

Do you notice a change in your relationships with colleagues/friends/family? Has your view of other people changed?

Is there a difference in how you view the world around you? Or how life may be for you in the future?

- What do you think has brought about this change(s)?
- Has anything been unhelpful?
- What have you found helpful?
  
- **[IF SAY NO]:** What in your view has made change difficult?
- What do you think would have made a difference for you?

6. Thank you for your taking the time to speak with me today. Finally I would like to hear about what's next for you in life?

**Further prompts:**

Can you tell me more about that?

In what way did "X" affect "X"?

What was that like for you?

What do you mean? How does that make you feel?

How did you make sense of that?

Can you give me an example?

**Ending the interview:** Thank the person for taking part, ask them if they have any further questions.



77 mother in law wants one. [great] People say that they really good, and my brother is an artist he can't believe I  
78 can do them and neither could I. So there is all these little things that I was taught [yes wonderful] I try to...but  
79 it is still.... Jane tell you if she's here... tell you, that it does not always work ...and I need to be reminded [I see, wife-suppor  
80 I see] why don't you go out and have a walk?  
81 I: So it sounds like, you've mentioned there, that your wife supports you with by helping you take a deep  
82 breath and step back if you're feeling...worried, are there, are there other ways people have been supporting  
83 you do you think?  
84 J: Umm yeah, lots of things... I don't want anybody to treat me with kid gloves, or on eggshells, but I suppose  
85 they have been... but, erm... the kids understand that, you know...can understand why I can't sit down after my  
86 dinner until I've tidied everything away, but they understand that and they try and make it a bit easier... things  
87 like that yeah, support, lots of support from family. It's all brilliant and I want to repay them by not being such  
88 an arse... and I do realise I'm doing it, yet... but... it takes someone... takes me to twig ... or somebody to  
89 remind me, normally one of the kids to remind me and say calm down, [oh yeah of course] Jane will give me  
90 the look... she's in the kitchen (shouts) you're not listening are you? Ah she can't hear as the fan is on.  
91 I: I mean, so you kinda told me about this already, perhaps...if you were to try and compare life now, to what it  
92 was when you were first diagnosed with PTSD in February, do you notice any changes at all? Perhaps in  
93 yourself, or in your relationship with others?  
94 J: Yeah yeah  
95 I: What kind of changes do you notice?  
96 J: All for the better really... I ... I'm... nowhere near as sad as I was. I can talk about the problem. It is a memory  
97 now, the memory is something I saw...something that I was involved in... is a memory, just like everything else  
98 is a memory... I can actually say the word Bosnia now, whereas before even... even...just saying the word and I  
99 would break down, I couldn't handle it. [yes yeah] In the beginning I couldn't say about what happened and  
100 now I can talk about it, I understand it all... I understand why it happened like it did... got different views on  
101 what happened, and why people did what they did... but I'm not anywhere near, I don't think I am ...Jane may  
102 think differently, I don't think any different.... Sorry, I mean I think I'm a lot different to what I was.  
103 I: Yes, I see, I see. And I wonder, what difference it makes to you to be able to talk about what happened, what  
104 happened now?  
105 J: A massive amount. It's a weight. Know the old saying, a problem solved is a problem shared... that kind of  
106 thing, to get it off my chest, like I did, when I started talking to (name), the psychologist, when I first started  
107 talking to her about it, I stopped having night sweats. Stopped having the night sweats, and started to feel like  
108 I could discuss it... and I just felt physically better. I wasn't as tired, my memory started to pick up as well. I still  
109 do the old forgetting what I came here for, but I laugh about it now. Whereas before, I was worried about  
110 it. But it doesn't worry me now, because I know it's just me. I know it is just my mind working overtime  
111 with different things. I know the reasons... the biggest thing, was knowing about the diagnosis, knowing the  
112 reason for why I was like I was, were completely normal given the situation. And it wasn't me going round the  
113 bend. I laughed about it the other night at a BBQ I had the charity sweatshirt on because it got cold, and one of  
114 the lads said "oh I live near there", "alright yeah?", "I live in Eggham". So I said, "it's right near". "So what do  
115 you work there? do you do anything?". I said "no no", I said. And my mate Gav turned round to him, "no he's  
116 an inmate, inmate there, was mad as a box of frogs". He sort of looked and then...I started laughing, and then



people being wary

humour to cope - associated with being in the military

once  
more

117 he realised that I was alright, it was, it was a bit of joke and we made of fun of it. Light-hearted military way  
118 again you know.

119 I: And is this a new thing, being able to laugh, laugh about what happened, or is this something you've doing  
120 for a while?

121 J: Yeah, yes. It's a new thing. Before I went there, on a 6 week thing, before I went there... I was embarrassed. I  
122 thought I'd let down... I felt like the world is coming down around me... I was embarrassed about being like I. Shame.  
123 was. In the beginning I was embarrassed about having PTSD. But now I realise there's no need to be  
124 embarrassed. You know, it's fine. *PTSD* Change in how he sees himself.

125 I: This might sound like a bit of an obvious question - a silly question. What do you think looking back now, why  
126 do you think you felt embarrassed, what was that about for you?

127 J: It's not the military way to admit you're not feeling... The military way, is... in my opinion... then as well, and  
128 beforehand, was that as a man you're meant to be the strong one. The military way that you ... and it is  
129 drummed into you from day 1, that whatever you come across you overcome it, you keep your gob shut. And I  
130 found out that I didn't have to anymore, because it is completely normal to want to talk about it. And I have  
131 been talking about it, so now I do... I'm not embarrassed, I'm not embarrassed about the fact that I felt let  
132 down as well. I felt I'd ... I wasn't as strong as I thought I was. And you know, if I was still in the army and had it,  
133 I probably wouldn't have spoken to anybody I would have just carried on. The fact that, you know, I am out of  
134 the situation now, I can talk about it. I'm not embarrassed anymore. [no no great] Does that make sense?

135 I: Yes it all sounds like... it's perhaps making a bit more sense perhaps than it did previously. Thought that was  
136 interesting what you said about men being strong ones and I know that is quite a lot part of our British culture.  
137 Do you have any ideas about where that comes from you in particular?

138 J: For me?

139 I: Yeah

140 J: It's the... First of all, it's the way I was brought up, you know, chin up, don't cry. My dad died when I was 9  
141 and I don't remember crying about it. Whether I did I don't know, I don't remember it. And you're always told  
142 military wise, the first thing is grin and bear it, chin up, we don't do that sort of thing in the army... but because  
143 I joined when I was 20, I don't know how I felt beforehand, whether that was the kind of thing, the kind of  
144 ideas I had, because I can't remember that far back ... [of course yeah] but erm... it's just the way that I've been  
145 told... and erm... it's deep rooted, I suppose. But now I know it's not. The barrier has gone.

146 I: Yes I see. And you talked about your childhood, and is that idea of men being strong, you talked about it  
147 being in the military as well. Do you know people now - or did you know other men, who felt very much the  
148 same way as you about being strong? Was that very much part of the culture of being in the military do you  
149 think?

150 J: Erm I've got three good friends - well two friends and one sorta erm, mate, who are all ex-military, and we all  
151 did different lengths of time. And the two - three - of us, who did... Dave did 12 years and me and Craig did 10  
152 plus, and we, and we, we all of us now are more... because we are retired are more, more ... easy-going... and  
153 we do talk about it, things like that, and we do show ... compassion and... what's the word for it, err you know,  
154 when you cry when you watch a film ... [yes yeah] ... that kind of thing. Where is the other friend, Craig, Gav  
155 sorry Dave, he only did 9 years but no, it was less than that, 6 years, but now he's a policeman... [I see] and he



## Appendix 7: Example of subordinate theme table.

This table was printed out and further notes, highlighting and re-arranging of quotes and themes was done by hand.

<b>Relief of receiving the diagnosis (superordinate theme)</b>		
	<b>Quote</b>	<b>Notes</b>
4	It had been going on for <u>so long</u> . Erm, what I was going through was just sort of <u>second nature</u> in a way, that way I was dealing with it was second nature. So it was a mixture of shock, but also sort of a blessed relief I guess.	Length of time prior to diagnosis, PTSD going unnoticed in life. Relief.
3	It was a relief	Relief-repeated
<b>Breaking the silence (subordinate theme)</b>		
1	As soon as I started off-loading, it just got easier and easier, and... I've <u>uploaded everything</u> now and that's it. Definitely talking about it is the initial ...massive thing to do— it's not the answer... 100%, but until you do that... you can, that there is somebody there who will listen and once you realise that, you are on the road to recovery	Over-coming barriers to being honest about difficulties. The beginning of the road to recovery. Finality "everything?"
1	I'm... nowhere near as sad as I was. I can talk about the problem	Talking bringing relief, "the problem", external, one thing?
5	Put your hands up, get help don't be such an idiot	Surrender? Frank talking
8	Realisation of what I've been like and what I've been through and I don't really have a lot to lose anymore, erm...I think it's just taking that step I often said to my <u>therapist</u> , even... erm... in sending off the paperwork for combat stress and then a year later putting it in the post box, it's like these massive massive barriers, and then finally walking of combat stress after being diagnosed and saying I'm getting better, and things like that. It's the stigma and the want to not to tell people just goes down and down and now	The challenge of seeking help, how the shame seems to lift after going to CS. Emphasis on it being him, noticing changes in self across time. Stigma less after Tx
1	You're always told military wise, the first thing is grin and bear it, chin up, we don't do that sort of thing in the army...	Militarised masculinity? Ingrained in training
6	I think the military back ground of...of..you don't sort of whinge about things, <u>you don't bitch</u> and moan...[break] ... you didn't want to show a level of weakness	Bitch – female trait? Talking=weakness
6	There were girls around, so there were females to talk to...[break]...you were very much in that remit of being you're with the <u>lads</u> and this is how you're expected to behave	Again links to female trait of talking – "laddy" behaviour, norms.
4	I think it's primarily a <u>male environment</u> . You know, you're a <u>team</u> , you've got this feeling you know, if you pull out for any given reason you're sort of letting the other guys down	Masculinity, letting people down. Upholding identity as lad and strong
4	Until I went to combat stress and we obviously spoke about it in depth, there were some real sort of eureka, jaw dropping moments you know, when you're like "oh wow" you know...[break]... it sort of fell into place.	Experience of learning about the diagnosis, power of talking nad sharing.
4	I didn't tell them I was <u>self-harming</u> , I had been for 20 years- were the things I should've said which would have giving them the markers, so they didn't really spot it and	Long-term silence, isolation, the shame associated with

	...[break]... just my lack of honesty and I was quite ashamed to sort of let people down you know, so I just didn't sort of get the help	acknowledging difficulties
4	It's just like a protective shield they build	To protect shame, hid weakness
9	Our marriage has been fairly stressed...[break]... It was worse in the years when I had been diagnosed with PTSD but I hadn't erm...accepted it or didn't even know about it	Diagnosis and understanding has aided relationships.
6	that I had been having quite a few of problems previous to the diagnosis sort of, you know mood, aggression, relationship problems things like that	Diagnosis as a watershed, point of change
6	Our marriage was a bit up and down and we weren't really sure where we were going, and we actually sat ...randomly and said "right, what is going on?" and it was me. So, we kind of got to the stage where I needed help and so we went down that route and that worked	Taking responsibility for behaviour. –it's me. Later on he reflects as PTSD as something external to him...shift?
1	because we are retired are more, more ... easy-going... and we do talk about it, things like that, and we do show ... compassion	Masculinities change with leaving the military? ( <i>link with age below</i> )
6	The military way, is... in my opinion... then as well, and beforehand, was that as a man you're meant to be the strong one. The military way that you ... and it is drummed into you from day 1, that whatever you come across you overcome it, you <u>keep your gob shut</u> . And I found out that I didn't have to anymore, because it is completely normal to want to talk about it	Feeling silenced in the military? Influence of training. Despite de-stigma campaigns still a lot around?
<b>A big answer to a lot of my problems (subordinate themes)</b>		
8	it's almost like a big answer to a lot of my problems, maybe a short time answer, but... erm... it seems however bad an individual's situation and you may in the back of your mind have an idea of why you might be suffering in this way, it is actually nice to sit down there and have someone look at you and say this is why you're here, and you have been diagnosed. And it sort of puts a lot of answers, it doesn't excuse anything you may have done, but it gives you a ... at least puts things into a box, ready to be processed if you like...don't want to hear it and once you hear it, it does give you some <u>clarity</u> , all the barriers are down, you know, <u>you're not worrying about the stigma so much anymore</u>	Validation from someone else that you're suffering? The difficulty of "facing" it, but once you do the stigma doesn't impact as much – due to normalising on course?
3	It made me <u>understand</u> why I was ... apathetic about things, why I was, getting angry about things, why I wasn't bothering to get up in the morning... why I just erm... hide myself away really... I used to spend... hours at a time really, just going nowhere. Just out for a walk, thinking about nothing...	Distress he was in prior to diagnosis, the importance of getting an understanding which the diagnosis gave.
6	I had been having quite a few problems previous to the diagnosis sort of, you know mood, aggression, relationship problems things like that.	Problems, life before – able to reflect on this since treatment?
1	It did just make me stop and think, scuse my French, holy fuck, <u>yeah that's me all over</u> , all the things that they were asking me about, when I gave him the answers and they were <u>ticking them off as signs of PTSD....</u> And it's all sort of fitted together	Fitted together, sounds mechanistic and clear cut, helpful? Concrete understanding?
7	To have somebody with letters after their name saying the	NB to have someone

	reason that you've done this and been like this is because of this, it's kind of a nice...	professional, experiences, hierarchy?
6	I did finally accept and realise there was something going on a little bit more than just being a bit of a dick.	Understanding of it being something internal, <b>me</b> ?
9	I had some of the symptoms of PTSD, but I didn't have any of the...causes of PTSD so, it was anxiety with really no idea of why I had anxiety	What is PTSD, cause? Linked to anxiety...
9	Three or four psychologists have ... poured doubt on my diagnosis on several occasions because I didn't have any visual flashbacks	Power of feeling invalidated by professionals.
2	It wasn't a shock, I was expecting it really.	Unsurprised by Dx
7	it wasn't a surprise, it was no complete out of the blue ....but it was very much a <u>relief</u> and because it's a place in combat stress I knew one that I had been given the go ahead to get treatment and two I was in the right place to get that treatment	Diagnosis meaning treatment, confidence in combat stress being the "right" place? Suspicion of civilian services?
4	It was a bit of a shock, but it was comforting in a way	
7	Actually refreshing, it was a positive, it was... erm, it gave me an ability to ...erm... it gave me an opportunity to be able to move towards a <u>solution</u> ...or kind of suddenly I knew what the problem was	Good thing, knowing what the problem was helpful for thinking of solutions. Hope?
7	I thought "this is a positive thing, that's great, let's get it sorted" whereas other people looked at it and thought well that's quite good now it justifies... or I've got a label now that I can pretty much blanket throw over everything you know	Disparaging of others? Own active approach. Proactive,
8	not the worst thing in the sense it gave me a few answers to the thought that I was <u>losing me mind</u> [yeah yeah] a little bit of clarity to be honest, at least I sort of had the <u>target</u> in front of me.	Militarised language "target", fear of madness or losing mind?
9	A lot of people do have denial of PTSD because you don't...necessarily you know, even though everything fits, it's difficult to believe you personally have PTSD, you feel you are stronger than that and you shouldn't have it.	Strong people don't get mental health problems?
<b>Reassurance I wasn't going mad, or horrible... (subordinate theme)</b>		
1	I always thought it was erm...just people being weak...until, until I was shown that it isn't, because now, I know, I know it's pretty normal	Link with weakness, but normal- meeting others and diagnosis
7	Thought I was going <u>mad</u> , or I was <u>horrible</u> or....I'd... been left to my own devices. And...erm... [hmmm] and in this case, with the particular <u>malady</u> it... it's not that helpful. So to have somebody with letters after their name saying the reason that you've done this and been like this is because of this, it's kind of a nice...	Diagnosis separates it from being "you"? NB of professional opinion/diagnosis. Malady... fear of mad
2	I know I'm not going mad now, I know the reason why	PTSD not equated with madness, he also spoke it as a physical thing?
1	The biggest thing, was knowing about the diagnosis, knowing the reason for why I was like I was, were completely normal given the situation. And it wasn't me going round the bend	Getting an understanding of why.
2	Your world isn't just falling apart it's.... cos you know, that	Having a diagnosis

	you know there's a reason behind why you get anxious about something ....or you know you ruminate so much.... About something... or you know, or you get so angry about silly things ...	was useful for aiding understanding of behaviour.
1	It wasn't just me ... and it was just me being...oh you know, my personality. It wasn't just me being... erm it was something I could get rid of, or perhaps or deal with... or at least control	Importance of getting control, diagnosis externalised problems.
8	Puts things into a box, ready to be processed if you like...don't want to hear it and once you hear it, it does give you some clarity, all the barriers are down, you know, you're not worrying about the stigma so much anymore	Externalised PTSD, sense now he can do something about it.
1	It was like someone opening the blinds and this new thing, seeing it for the first time ...because I have never ever seen it in the 20 years since it happened ...20 years down the line, I was still, I had ingrained this thought in my mind, and then she gave me another way of looking at it	Length of time that people might "suffer in silence" for, idea of being stuck and therapy helping to get over that?
9	Whilst a lot of people you know might have had two or three individual very stressful experiences, people getting injured and that sort of shock, I didn't have that but I had a lower level thing which was repeated a hell of a lot more. And to a certain extent, probably more brain-washing	PTSD being in the brain, intense stress – ideas of what is trauma?
3	PTSD just can come from going through the whole process of becoming soldier... this whole <u>militarisation of your mind</u>	Key understanding – military itself can lead to PTSD
2	It doesn't matter what mental health condition is some people do look at you in a different way ... you know...but I tried to explain that it's a mental and physical ... mental and a physical thing.	NB its thought of as not only a mental thing- hierarchy of injuries?
1	was really worried there was something physically wrong with me, like night sweats... and when I found out they were because I perhaps dreaming or thinking about the issue, it made me feel a whole lot better, immediately knowing it was something normal, really, I wasn't weird	Getting a name, reason and understanding v important.

## **Appendix 7: Excerpt from reflective diary.**

### **3<sup>rd</sup> September 2015 – two interviews arranged.**

I have just spoken with John which I really enjoyed and has left me feeling extra motivated for my research. He was very eloquent in his descriptions of what he had found useful to his recovery since treatment and I was struck by his openness and honesty about his experiences. John placed a lot of emphasis on how he “wanted” and “willed” things to get better which he perceived to have driven his “recovery”. This made me think of western discourses of individualism and how as clinicians we sometimes speak of patients needing to be wanting, willing and ready for therapy – I wondered where these ideas may have come from for John, was this related to his own personal preference for exerting self-determination, or something drilled into him from years in the army or even therapy? He also spoke of the connection with other veterans and how crucial their support was, and how it seemed so much of his “recovery” was due from simply no longer feeling alone in his suffering.

John was very reflective about his life and how his military experiences and upbringing had influenced how he’d coped with PTSD. It was interesting that he thought being retired from the army had meant he was less concerned by social norms of how he should behave- interestingly he considered this across the generations, both by talking about his daughter’s partner but also his father and how they perform masculinity. This led me to think of men I know and how I could identify with John’s description that sharing or speaking about emotions can be a taboo. However for John being able to connect to his emotions also appeared to be about leaving the military, and he seemed struck by his new understanding that talking about emotions is “normal” which seemed important for his recovery. This made me consider western ideas of catharsis and assumptions I might hold as a psychologist trainee, that talking is a useful process for people.

John spoke frequently of PTSD being a mental and physical condition, which makes sense since he had been experiencing physical symptoms of night sweats etc. However, I also wondered whether it also may be that it felt easier to admit to a physical health problem than a mental health one. He used a lot of imagery in his answers which gave me a vivid insight into his life.

John saw recovery as life-long journey, in the sense that “there would always be ups and downs”. He spoke of seeing a psychiatrist and I noticed I made a quick assumption PTSD as incurable probably stemmed from psychiatry. But perhaps John now sees his difficulties associated with PTSD as part of him and something that will always be there?

Post interview with Dave: After speaking to John and a short break, I interviewed Dave. I was instantly struck by how different the tone of this interview was to when I had spoken with John – although Dave said he was keen to take part, his interview was notably more strained. He did not elaborate much on questions and answered matter of factly without much reflection on how events had affected him emotionally. He felt the diagnosis had been unhelpful and exacerbated stigma from family and friends, which made me think of critiques of PTSD and how the diagnosis can pathologise people. I was especially struck by his phrase about being “branded” with PTSD. This also triggered my thinking as to how useful it may be to go away for 6 weeks of treatment, as it may make it especially difficult for some people to return to daily life and rake up memories for them of leaving the army. I was struck again during this interview of the power of meeting other veterans with similar experiences and how this appeared to be a life line of support for people.

After feeling buoyant after my conversation with John, I felt sad and frustrated after speaking to Dave due to his negative experiences of stigma and his feeling so trapped with the PTSD label. Dave’s interview had been tough as he not been especially reflective on his experience of PTSD, which I will seek supervision about – was it my questions? Could I have done more to “dig deep” into his experience? Or perhaps, did he not feel in a place to be as reflective as would have been useful for this research, or was this not his personal style? During the debrief he said he had found it interesting and thought speaking on the phone was convenient and comfortable for him, I wondered if we might have had a richer conversation face to face. I also wonder how I will ensure his voice is present in the analysis, if other participants’ interviews are as rich with “sound-bites” and usage of metaphor and imagery as John’s, which I feel will be lends itself to this sort of analysis.