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Doctoral Thesis

Veterans' Experiences of Reintegration and Successfully Managing Post-Traumatic Stress

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Doctorate in Clinical Psychology

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Word Count

	Text	Appendices (including tables, figures and references)	Total
Abstract	300		300
Literature review	7998	6945	14943
Empirical study	7999	6259	14258
Critical review	3998	1034	5032
Ethics proposal	3689	2362	6051
Total	23984	16600	40584

Abstract

It is established within this thesis that some veterans experience problems reintegrating into civilian life after discharge from the military. Difficult and traumatic events during service can cause an emotional aftermath that includes post-traumatic stress and avoidant coping. Much of the veterans' research literature is quantitative, so this thesis sought to build upon the small qualitative research literature that gives a voice to this unique group of individuals. First, the literature review explored female veterans' experiences of reintegration into civilian life, synthesising 11 studies using Noblit and Hare's meta-ethnographic approach. Findings outlined a process within six themes that started with experiences in the military and ended with reintegration. Implications included improving female veteran's access to peer support on discharge, educating healthcare practitioners to help identify past military service and particular needs of female veterans, e.g. gender-sensitive support, and further qualitative research into military sexual trauma and experiences of reintegration cross-nationally. Secondly, the empirical study focused on veterans' experiences of successfully managing post-traumatic stress. Semi-structured interviews were conducted with six veterans and data were analysed using interpretative phenomenological analysis. Findings within three themes explained how participants went on a journey from denial of their difficulties and hitting 'rock bottom', to eventually 'circling back around' to gain a positive sense of identity and belonging within the veteran community. Implications included piloting and evaluating peer support groups as an early intervention for veterans within National Health Service and community veteran organisation settings, as well as promoting referral to community organisations for informal peer support. Finally, a critical appraisal expanded on discussions of the military-veteran identity and veteran-civilian divide as broad problematic concepts across both findings. The section ended with consideration of bias that may come from

having contact with the participant group outside of the research. Further implications are recommended throughout this section.

Declaration

This thesis reports work undertaken for the Doctorate in Clinical Psychology at Lancaster University Division of Health Research between June 2017 and December 2018.

This thesis is the authors own work, except where due reference is made. This work has not been submitted for the award of a higher degree elsewhere.

Name: Gemma Parry

Signature:

Date:

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I would primarily like to thank the participants who took part in the empirical study, it was an honour to listen to and document their stories of successes and hardships. I extend my thanks to the participants of the literature review studies and the study authors, who made the review possible.

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Finally I thank my Dad for all the proofreading, and Mike, my family and my friends for all their support and encouragement which kept me ‘chipping away’.

Contents

Section One: Systematic Literature Review

Female Veterans' Experiences of Reintegration into Civilian Life:

A Qualitative Meta-Synthesis

Title Page

Full Article Title

Female veterans' experiences of reintegration into civilian life: A qualitative meta-synthesis

Abstract

The number of women serving in the military is increasing, with wider access to roles in recent years having led to increased exposure to combat trauma. Military sexual trauma has been frequently reported within this population. A small number of qualitative studies outline particular challenges experienced by this minority group during their service and reintegration into civilian life. This systematic literature review aimed to synthesise reintegration experiences outlined in these articles. Eleven articles met the inclusion criteria for the review. Findings centred around six themes: (1) a woman in a man's world, (2) the immediate emotional aftermath, (3) an outsider again in one's own home, (4) civvies and civvy systems, (5) forever changed and between two worlds, and (6) reflection and reintegration. Implications included developing female veterans' resources in the community and further qualitative research into experiences of military sexual trauma.

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Female Veterans' Experiences of Reintegration into Civilian Life: A Qualitative Meta-Synthesis

The number of women serving in the military is increasing, with wider access to roles in recent years having led to increased exposure to combat trauma. Military sexual trauma has been frequently reported within this population. A small number of qualitative studies outline particular challenges experienced by this minority group during their service and reintegration into civilian life. This systematic literature review aimed to synthesise reintegration experiences outlined in these articles. Eleven articles met the inclusion criteria for the review. Findings centred around six themes: (1) a woman in a man's world, (2) the immediate emotional aftermath, (3) an outsider again in one's own home, (4) civvies and civvy systems, (5) forever changed and between two worlds, and (6) reflection and reintegration. Implications included developing female veterans' resources in the community and further qualitative research into experiences of military sexual trauma.

Women are currently the fastest growing minority group in the Western military (Bean-Mayberry, Batuman, & Huang, 2012). Their military presence has undergone significant changes across time and cultures, such that it has become an increasing focus of research in health and social sciences (Eichler, 2017). With expectations that the proportion of women in the military will keep growing (Department of Veterans Affairs, 2013), it is pertinent to examine issues relating to this minority within what is widely recognised as a heavily gendered institution.

In Western nations women have not always had permanent military membership and indeed their perceived value has altered significantly throughout history. Segal (1995) explained variation in female military participation cross-nationally based on three factors. The first is military needs and structure, depending on demand for 'manpower' during perceived military threat and roles women are deemed capable of. Secondly, the level of gender integration in the military reflects gender integration within the labour force more broadly. Finally, Segal argued that social construction of gender and family structure within a culture impacts greatly on the nature of women's contributions to the military.

In line with Western cultural shifts in gender equality, it has become more acceptable for women to fulfil occupations away from the home and roles traditionally considered masculine (King, 2013). In the United Kingdom (UK) and United States (US) women have been permanent military members since the late 1940s, whereas before this they were recruited only in times of great need. This has varied across Western nations, with some only admitting women into regular forces more recently (e.g. Italy in 1999; Nuciari, 2006). In some non-Western cultures, in contrast, women have had an established presence for longer and are conscripted into national service, such as in Israel, North Korea and Eritrea (Central Intelligence Agency, 2018).

Recent data on prevalence shows high variation across nations. Amongst North Atlantic Treaty Organisation (NATO) members, percentage of females ranges from 2.1% in Poland to 13.6% in Czech Republic (Schjølset, 2013), whereas in the UK women constitute 10.1% of the regular armed forces (Ministry of Defence (MoD, 2015). The US military currently has the highest percentage of all Western countries, at 16% for enlisted and 18% for officer personnel (Department of Defence, 2016). Prevalence varies in non-Western cultures also, with some areas where women make up a larger proportion, for example in South Africa women make up 21% of the South African National Defence Force (Seegers & Taylor, 2008).

Strategically, the diverse skill set resulting from recruiting a range of individuals is valuable for increasing "operational effectiveness" in military organisations (Rohall, Ender, & Matthews, 2017, p.2). Having personnel from diverse groups is especially useful where operations occur within different and complex cultures. For instance, during conflict in Afghanistan, civilians saw female and Muslim personnel as more approachable, which helped build good relations to support civilian safety and gain vital intelligence (Bryce, 2017). The growing diversity of women's roles is notable and has become a topical issue. To illustrate, approximately 7,500 US women served in the Vietnam war, with the majority providing nursing or clerical support (Bellafaire, 2012). In comparison, during the conflicts in Iraq and Afghanistan 154,536 US female personnel were deployed in a full range of combat support roles, including nursing, medicine, aviation, mechanics, intelligence, transport, and many others (Street, Vogt, & Dutra, 2009). The most current significant development regards changes in eligibility for combat roles. Close combat is viewed as "the most demanding military occupation", and women have been historically excluded under the view that it is a man's role (King, 2013, p.14). This is changing, with the US military increasing female involvement in some combat roles in line with equal access to employment in the 1990s

(Zeigler & Gunderson, 2005), and similar changes in the UK since 2016 (MoD, 2016). Some military organisations have a higher range of close combat roles available to women than the UK and US, including Canada, France, Germany, Israel and Poland (Cawkill, Rogers, Knight, & Spear, 2009). The Nordic countries are notable for having equal access to all close combat roles (Cawkill et al., 2009).

Irrespective of role, women who are deployed are likely to experience traumatic events which pose threat to their own or others' lives (Fitzgerald, 2010). For example, in Operation Iraqi Freedom only 8% of returning Army females fired a weapon but 74% experienced enemy fire (Dutra et al., 2010). It has been increasingly recognised that women have similar exposure to combat-related trauma as men, when in combat or combat support roles (Mattocks et al, 2012). Mental health difficulties have been widely reported by women on leaving the military, including Post-Traumatic Stress (PTS; Conard & Sauls, 2014), depression, adjustment difficulties (Haskell et al., 2011) and alcohol misuse (Hassija, Jakupcak, Maguen, & Shipherd, 2012). Difficulties with PTS, depression and alcohol misuse have been linked with increased combat exposure (Hassija et al., 2012).

Some difficulties female veterans experience following military discharge have been linked to Military Sexual Trauma (MST) and sexual harassment during service (Hyun, Pavao, & Kimerling, 2009; Woodhead, Wessely, Jones, Fear, & Hatch, 2012; Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, & Frueh, 2007). Demers (2013) defined MST as "sexual assault or repeated threatening sexual harassment that involves someone against their own will" (p.490) and commented that risk of MST for female personnel was "disturbingly high" (p.490). In support of this, one in five female veterans reported MST to the US Veterans Health Administration (Department of Veterans Affairs, 2010). A meta-analysis by Wilson (2018) found even higher rates in female veterans (38%), perhaps indicating under-reporting within health services. Wilson (2018) provided comparable data for male veterans (4%),

highlighting MST as a problem particularly affecting women. Furthermore, Dutra et al. (2010) found that both combat trauma and sexual harassment on deployment were commonly reported by female veterans, however sexual harassment was the biggest predictor of symptoms of PTS and low mood. These findings raise concerning issues about the impact of military service on female veterans' mental health.

It has been well documented that reintegrating into civilian life after military service can be difficult for veterans. Morin (2011) reported that 27% of veterans find the transition difficult, and the biggest contributing factor for this was experiencing psychological trauma. Considering high levels of trauma and MST reported by women, it is important to further explore women's reintegration experiences. Jones and Hanley (2017) reviewed qualitative literature on female veterans' experiences of returning from deployment, and found that participants brought the war home with them, struggled to adjust, and experienced loss and "failed belongingness" (p.311). Prolonged separation from family and friends who usually provided support compounded the difficulties participants experienced. However, over time participants made sense of their experiences and grew as individuals. Although many women who leave the military reintegrate successfully (Leslie & Koblinsky, 2017), some experience particular socio-cultural challenges. For instance, female veterans are more likely to be single parents than male veterans, and to divorce from their spouse and be primary care giver on their return, a role they are often expected to step back into quickly (Clever & Segal, 2013). Reintegration difficulties are more common for female veterans experiencing mental health problems and problems reintegrating can further impact on mental health (Vogt et al., 2011), creating a downward spiral of emotional and social difficulties.

Social support has been highlighted as a strong mitigating factor for veterans experiencing mental health problems and difficulties transitioning (Demers, 2011). Unfortunately, female veterans have reported feeling excluded from accessing support within

healthcare services and veterans' organisations, due to being disbelieved when disclosing past experiences, which made them feel alienated (Zinzow et al., 2007). Bean-Mayberry et al. (2012) conducted a systematic review of quantitative and qualitative literature on women veterans' health for the US Department of Veterans Affairs. They identified a need to "organize and deliver gender-specific and gender-sensitive services in a system that has otherwise historically focused on treating men" (p.29). The review commented on a "sharp increase" (p.30) in research on women veteran's health in the US, but stated that more research was needed into post-discharge transitions for women specifically.

To summarise the rationale for the current review; the number of women in the military is increasing significantly, within a more diverse set of roles. Female military personnel are at greatest risk of MST during service and mental health difficulties on discharge are commonly reported. A review of the current qualitative literature on female veterans' experiences of reintegrating into civilian life is timely, as several studies have been conducted since the recommendation for more research by Bean-Mayberry et al. (2012). The review will expand upon and complement Jones and Hanley's (2017) review, which focused on experiences post-deployment. The review aims to synthesise current literature to gain detailed understanding of female veterans' reintegration experiences, to inform directions for further research and implications for healthcare and voluntary services.

Method

Meta-Synthesis

Synthesising qualitative studies allows a complex theoretical picture to emerge for a topic that is difficult to understand (Atkins et al., 2008). Schutz (1962) defined two levels of interpretation within social sciences, first order constructs – participants' understanding of their experiences, and second order constructs – researchers' interpretations about participants' experiences. Synthesising studies introduces a third level of interpretation, based

on what has already been constructed and re-constructed (Britten et al., 2012). There are different approaches for synthesising qualitative data, and selection depends on the epistemology of the research (Finfgeld, 2003). This review took the epistemological stance of critical realism, assuming there is a 'real world' that we can gain knowledge of, whilst also allowing for the idea that our understanding of the 'real world' is influenced by our own perspective (Archer, Bhaskar, Collier, Lawson & Norrie, 2013). The meta-ethnographic method by Noblit and Hare (1988) was selected, as it allowed the original context of participants' accounts to be preserved but also for interpretative themes to emerge across the data (Dixon-Woods, et al., 2007). This was deemed particularly useful in relation to gendered issues within the military, which needed to be preserved and explored to fully understand how female veterans navigate reintegrating into civilian life. See table 1 for a summary of the seven steps of the meta-synthesis, as outlined by Noblit and Hare (1988).

Searching for Studies

The first step was to define the research question; set as 'how do female veterans experience the transition to civilian life?' Lancaster University library services were consulted regarding searching for relevant literature, and advised including the following databases: PsycINFO, Academic Search Ultimate, SocINDEX with Full Text and Wiley Online library. The library service reviewed the search, including full terms, once complete. The search was organised around four categories; veterans; women; reintegration experiences; and qualitative methods (see table 2 for full terms). Within categories terms were searched in titles and abstracts, combined using Boolean operator OR. The four categories were then combined using AND. Relevant subject headings were selected using database thesaurus functions. The University library service recommended InterTASC Information Specialists' Sub-Group Search Filter Resource (Glanville, Lefebvre, & Wright, 2017) for comprehensive qualitative research search filters. An initial search carried out in

February 2018 yielded 1543 results. Due to a delay completing the review a second search in November 2018 covered publications from February-November 2018, yielding an additional 44 results; 1587 in total.

Inclusion and Exclusion Criteria

The second step of the meta-synthesis was to decide which studies to include. Studies were included where they: (1) were in English language, (2) were published in peer-reviewed journals, (3) interviewed a sample of female veterans, (4) focused on transition experiences following military discharge, and (5) used qualitative methods. Studies were excluded where they also reported experiences of male veterans, or did not focus on reintegration experiences.

The initial search retrieved 1543 identified articles, 489 were not published in academic journals, 43 were not in English, and 391 were duplicates (identified using EndNote). The author hand searched the remaining 620 articles, excluding those not meeting the inclusion criteria; 580 based on title, 26 on abstract and two from full text. Of the 12 remaining, two were excluded as they did not exclusively interview female veterans. Identified articles were checked for additional references; one was found. An updated search in November 2018 yielded 44 additional articles, 43 were excluded based on title and one based on abstract. This resulted in 11 articles being included in the meta-synthesis. See figure 1 for a visual diagram of the search.

Analysis

The analysis involved progression through steps three to six (see table 1). First the researcher read and re-read the papers several times to familiarise herself with the data, making notes on key emerging concepts. An Excel spreadsheet was created to record first and second order constructs (participant and researcher interpretations) expressed within each study. These were then closely considered for reciprocal translations, and themes were

formed as a result of this stage. The researcher then re-read included study papers to ensure themes fitted the analyses of each article.

To reduce bias within the synthesis the researcher consulted a research supervisor throughout the analysis, allowing her to reflect and respond to feedback on themes created, thus increasing researcher reflexivity. The researcher kept initial notes from the analysis and noted reflections on the process in a reflective journal. For transparency, tables 3-8 outline how each theme was constructed from the main concepts emerging from the data.

Appraisal of Study Quality

The quality of a meta-synthesis depends upon the quality of its included studies, such as the extent findings are influenced by researcher bias and flaws in methodology (Walsh & Downe, 2006). It is important to appraise study quality within a meta-synthesis, to ensure data being added to the evidence-base make accountable, objective and relevant interpretations (Hannes, 2011). Appraisal tools provide structure for assessing study quality, although they differ in factors they consider to affirm quality. The Critical Appraisal Skills Programme (CASP; 2010) was selected, as it is a thorough assessment tool that is widely used within qualitative reviews (Duggleby et al., 2010). The tool has two screening questions and eight questions evaluating aspects of the research, e.g. whether the method fitted study aims and whether the analysis was sufficiently rigorous. To differentiate quality, studies were scored out of three for the eight questions as outlined by Duggleby et al. (2010). A score of one indicated that evidence for that dimension was weak, two meant the issue was addressed but given only moderate coverage, and three that the issue was extensively justified and explained. Maximum score was 24. The quality assessment did not aim to exclude studies but to become familiar with study details prior to analysis, and to be conscious of weight in the analysis given to studies based on quality.

Findings

The included studies interviewed 255 female participants, aged between 18 and 91. All studies were conducted in the US except one, which was conducted in Ethiopia (Negewo-Oda & White, 2011). Most used semi-structured interviews in person or by phone, except two which used focus groups (Demers, 2013; Leslie & Koblinsky, 2017). Studies included veterans deployed in various conflicts from World War 2 to Operation Enduring Freedom in Afghanistan. Studies included female veterans from all branches of the military within a range of roles. See table 9 for full study characteristics. CASP assessment generated scores between 16 and 21 (out of 24) which were considered acceptable (see table 10 for scores).

Six themes were derived from the analysis, which will be subsequently presented as the final stage of the meta-synthesis, using quotes from study authors and participants to support findings. Themes were named to reflect language used by participants and authors of the included studies, in order to remain close to the original data.

Theme 1: A Woman in a Man's World

The first theme outlines participants' experiences within the military and on deployment, which featured heavily in most of the included studies, and provides essential context for understanding their experiences prior to leaving the military. It also describes how participants coped with what they endured.

Firstly, whilst on deployment, regardless of role, participants experienced the "violence of war" (Burkhart & Hogan, 2015, p.113). This included high danger posed by mortar, improvised explosive device or firefight attacks on base, in transport and on operation, and high exposure to death and traumatic events throughout, "My first casualty I saw was a suicide" (Conard & Scott-Tilley, 2015, p.234), "I had the unfortunate experience of having to kill a child, an Iraqi child" (Mattocks et al., 2012, p.540).

Additional gender-specific factors were also highlighted. Participants felt that within the military, they were a woman in a man's world, "an outsider" (Conard & Scott-Tilley, 2015, p.236) and under pressure to prove their worth, "I was doing the actual war, and I was doing a mental war, battling with my own peers…It was non-stop…They didn't want me to succeed" (Demers, 2013, p.500). Trying to fit in meant gaining balance between proving their worth and not standing out, as this could mean they were targeted as a threat to their male peers. Some adapted to this environment by developing a masculine "vibe" to fit in, "I kind of went out of my way to be as guy-like as I could" (Demers, 2013, p.499), and felt they became woman soldiers equal to man (Negewo-Oda & White, 2011).

For some, derogatory treatment and military sexual trauma (MST) were additional factors to contend with, although this was less frequent for medics in Burkhart and Hogan's (2015) study. Participants' experiences varied from "bullying type behaviour" (Burkhart & Hogan, 2015, p.117) such as insinuating that female colleagues were promoted due to intimate relations with male superiors (Mankowski, Haskell, Brandt, & Mattocks, 2015), to serious sexual abuse at the more extreme end. Some participants felt they had been fighting "two wars" (Demers, 2013, p.498),

> Women serving over there [Iraq] don't have to be worried about enemy fire. They have to be worried about the guy that's next to them…that's supposed to be protecting and taking care of them and a lot of times he becomes like public enemy number one for them (Mattocks et al., 2012, p540).

Unfortunately, these incidents could have an aftermath that involved further derogatory treatment and scepticism, which for some became more stressful and problematic to cope with than the incident itself (Burkhart & Hogan, 2015). Participants in Negewo-Oda and White's (2011) study did not mention MST but derogatory treatment within the structure of the institution was described, for example being required to report off duty when menstruating.

Participants saw social support from family, friends and fellow female military personnel whilst deployed as essential to mitigate the challenges they experienced. Some formed strong relationships quickly, "you skip all of the beginning parts in the friendship and you go right to best friends" (Mankowski et al., 2015, p.295). Participants also drew strength from developing themselves in line with military values and expectations, "they [military] were constantly reinforcing to me the importance of being a good person" (Burkhart & Hogan, 2015, p.116). They gained pride in themselves by building confidence, work ethic, team work and leadership skills, integrity and respect from others (Burkhart & Hogan, 2015; Negewo-Oda & White, 2011). Building a strong identity as an independent, competent person was important not just to fit in, but to cope with adversity.

Theme 2: The Immediate Emotional Aftermath

The second theme follows from the first, drawing together salient features of the immediate separation from the military. The central feature was a personal struggle with the extreme emotional aftermath of deployment experiences and the stark change in environment. Participants' return home felt solitary, with separation from the military family representing a final, and for some traumatic, loss amongst many others during their military career.

Mattocks et al. (2012) conceptualised the emotional aftermath of discharge as the "lingering effect of war" (p.541), which left participants on high alert and unable to relax. A structured process had made them vigilant, but participants found that they were unable to reverse this, "I was always scanning…I still have a heightened sense of awareness…I hate crowds" (Burkhart & Hogan, 2015, p.120). Intrusive memories of participant's experiences were frequent, and often for the first time they fully experienced personal losses they were unable to process whilst on active duty (Burkhart & Hogan, 2015; Conard & Scott-Tilley, 2015; Mattocks et al., 2012). Sleep difficulties and nightmares were frequently reported, and considered "a given" by one participant (Mattocks et al., 2012, p541).

Participants experienced a confusing and complex mix of positive and negative emotions, ranging from joy, happiness, relief and renewed connection, to feeling guarded, fearful, distant, subdued, sad and that life was surreal. One participant commented, “It was difficult to wrap your head around being at a swimming pool while the week before you were dodging mortars” (Maiocco & Smith, 2016, p.396). Emotional experience was described as problematically moving between two extremes, on one side feeling emotionally numb and on the other totally overwhelmed (Conard & Scott-Tilley, 2015; Burkhart & Hogan, 2015; Demers, 2013; Maiocco & Smith, 2016).

Compartmentalising emotions as a coping strategy was normalised and encouraged within military culture, as a short term effective strategy to complete a task. However, participants were concerned about the consequences of this on their relationships longer term, “It made me kind of insensitive to people. I don’t show a lot of empathy. I am not very emotional anymore” (Conard & Scott-Tilley, 2015, p.235). This general numbing of emotions was contrasted with uncontrolled and unpredictable outbursts of emotions such as anger, anxiety, sadness and shame with varying degrees, “Anxiety, out of nowhere; I get angry, like out of nowhere…from normal to ten like that [snaps fingers]…it’s so embarrassing and frustrating…that's probably one of the biggest hurdles for me” (Demers, 2013, p.501). One participant described herself as a “time bomb” of barely contained emotions on the verge of explosion (Demers, 2013, p.501). The response to such emotion could be extreme, with some participants discussing suicidal thoughts, previous suicide attempts and self-harm (Mattocks et al., 2012).

Some participants explained that for military personnel, showing emotion stigmatized them as having a weak character, and as a consequence they resisted seeking help with their difficulties (Mankowski et al., 2015; Mattocks et al., 2012; Maung, Nilsson, Berkel, & Kelly, 2017). This made the transition particularly troublesome for those with general mental health

difficulties and combat trauma or MST. Difficulties managing emotions alone led some to use avoidant coping mechanisms that they recognised were not helpful, such as excessive use of alcohol and prescription medication (Mattocks et al., 2012; Maung et al., 2017).

Theme 3: An Outsider Again in One's Own Home

The immediate emotional aftermath of discharge described in the second theme existed alongside participants' reconciliation with their home life, including partners, children, family and friends. This theme outlines how participants navigated this, encompassing feelings of disconnection from a family that had evolved in their absence, and being emotionally and habitually different.

Participants described the significance of missing out on important events and developments whilst away, "when I returned I didn't know my kids anymore…I was gone for a year and a half and so much changed in that time" (Mattocks et al., 2012, p.541). They felt unprepared for dealing with the practicalities of this,

> Everyone else gets to learn to be mom one day at a time. We come back and all of a sudden our child is on a different developmental level and we're trying to figure out how they got there, let alone what we're supposed to do next (Leslie & Koblinsky, 2017, p.112).

For some the role of caring for others had become alien to them because in the military they only needed to care for themselves (Kelly, Berkel, & Nilsson, 2014). Participants needed to adjust in their relationships, whilst also contending with the change in pace between their role in the military and home life, "it just comes to a screeching halt" (Leslie & Koblinsky, 2017, p111). Home life was described as more complicated due to it being less regimented, and some participants were overwhelmed by the choices they had to make.

Intimate relationships with partners and children were affected by participants having been "toughened up by the military" (Kelly et al., 2014, p.350), "you have to put up this barrier. If you don't protect yourself and not really let that emotion for intimacy or loving [go]…you would go crazy with [being] lonely, missing somebody" (p.352). It was hard to

switch this off on return to home life and some reported resistance to physical touch after seeing injury and death, or experiencing personal trauma such as MST (Leslie & Koblinsky, 2017; Mattocks et al., 2012). Some managed to reconnect over time, but for others difficulties that were masked while they were away further developed and made the transition more difficult (Maiocco & Smith, 2016). Positive support could mitigate difficulties and help participants adjust. However, some felt that sharing experiences risked overburdening loved ones who had little familiarity with the military context (Suter, Lamb, Marko, & Tye-Williams, 2006), "treating people that have been blown up and all that is not that relatable of an experience to most people you meet" (Mattocks et al., 2012, p541), and some feared judgement and rejection, "If I tell them the truth, then I'm going to lose this person's support too" (Leslie & Koblinsky, 2017, p.114).

Participants coped with reintegration into home life in two main ways, by making active efforts or by withdrawing socially, although an individual's journey could involve periods of both. Some adjusted by creating structure and routine in their lives, keeping occupied with practical tasks and finding work early on, "You sit around and you get depressed. And so, I went back to work [full time] less than 30 days after I got home" (Maung et al., 2017, p73). Some found that over time they were able to relax into civilian life and slow down (Demers, 2013, Maung et al., 2017). For others, difficulties were harder to overcome, leading to withdrawal and engagement in counterproductive coping strategies (Mattocks et al., 2012). Participants realised that withdrawal was unhelpful, but they struggled to communicate and ask for what they needed (Mankoswki et al., 2015).

Theme 4: 'Civvies' and 'Civvy' Systems

The fourth theme represents reintegration with civilians on a wider social level, and systems participants were required to navigate on their return to civilian life. Participants felt a divide between themselves and civilians that isolated them. Similar to within their close

relations, they felt civilians did not understand their experiences, and found it hard to trust professionals and their wider social circle with details of their experiences and emotions. It was difficult for some to connect with previous civilian friends, due to differences in life experiences and interests.

A significant irritant for some participants was that civilians' worries and what mattered to them seemed trivial in comparison with what they had endured and experienced (Maiocco & Smith, 2016; Maung et al., 2017),

> We [military personnel] realize the things that everyone takes for granted every day and it kind of upsets you when you've come back from living in a tent…and you come back and people are worrying about things like having to wait in a line because they have stuff to do (Kelly et al., 2014, p.352).

Participants in Negewo-Oda and White's (2011) study commented that civilians want women to act like women in a traditional sense, making anger and aggression undesirable responses that they had to minimise to avoid judgement.

Some found civilian life easier in ways, because they were not encountering the dangers of a war zone, but for others civilian systems were experienced as complex and frustrating to navigate (Kelly et al., 2014; Maung et al., 2017). One participant recounted,

> As a civilian, for me to shop for my family coming directly off deployment and then try to make Christmas dinner? It was a nightmare. I completely shut down…I walked outside and started crying because there were too many people, too many choices (Kelly et al., 2014, p.351).

In terms of finding employment, some participants reported easy integration into the civilian workforce which surprised them. However, others felt disadvantaged due to having few transferrable skills, and physical and mental health difficulties from their military service that limited their employment choices (Conard & Scott-Tilley, 2015). In one study the civilian workplace was experienced as challenging, due to colleagues lacking the discipline and commitment they previously found in military colleagues (Burkhart & Hogan, 2015).

Managing finances and getting the right medical care were reported to be major stressors, as was applying for state benefits, "that whole process, the drive up there, the evaluation, it was way worse than any of the combat situations…I dreaded having to be re-evaluated" (Mankowski et al., 2015, p300). Participants commented that they were unaware of available resources and felt that a more comprehensive and better funded reintegration programme was needed (Burkhart & Hogan, 2015; Negewo-Oda & White, 2011). Furthermore, some commented that community resources to help veterans were focused towards men (Demers, 2013; Suter et al., 2006), meaning they felt excluded. Where MST had been experienced from male military colleagues, participants did not feel safe or comfortable engaging with services that may include those who traumatised them (Demers, 2013). Burkhart and Hogan (2015) commented that feeling excluded contributed to social withdrawal, hiding military service and coping alone, "I just went into seclusion…I will deal with this on my own and it was hard. I would say that is like I hit rock bottom" (p.120).

Theme 5: Forever Changed and Between Two Worlds

The fifth theme elaborates on participants' changing identity and purpose on a more existential level. Reintegration into civilian life required participants to settle into a new identity as veteran-civilian, but there were challenges to be overcome. The theme outlines struggles around being between two worlds, which for some was familiar from their time in the military, and also feeling forever changed and grieving the loss of their previous self.

On return to civilian life participants found themselves struggling to find a place between military personnel and civilian, no longer identifying as either, "When I got back I didn't realize there was such a difference between the military and people who have never served" (Burkhart & Hogan, 2015, p.119). Some did not relate to the term veteran, seeing it as applying to men. Participants in Negewo-Oda and White's (2011) study experienced additional cultural identity struggles, due to women being respected whilst in a military role

but expected to resume traditional gender roles with no political authority on their return. They struggled to accept this, “I wish the respect men had for women would have continued after the war…but men revealed their real personalities and attitudes about women when we returned to the city” (Negewo-Oda & White, 2011, p.179).

Participants went from having a clearly established role and identity to experiencing at least a temporary loss in both areas, which if prolonged impacted on self-worth and was experienced as depressing, “I went from being special in my field…to being frighteningly devoid of identity” (Demers, 2013, p.503), “you go from, "I was making a difference when I was doing this in Bagdad" to "would you like some ice to refresh that drink sir?" (Kelly et al., 2014, p.351). It is unsurprising that many participants found themselves holding onto their previous identity (Suter et al., 2006), longing for the past (Negewo-Oda & White, 2011) and wanting to go back, “just send me back that’s how I felt, angry and frustrated” (Mankowski et al., 2015, p.298). Contributing to this was suddenly severing all ties with the military, which was particularly difficult for those with a strong military identity.

Some participants reported feeling fearful that they were forever changed, and destined to permanently experience strong uncontrollable emotions, relational difficulties, and lost identity and meaning (Conard & Scott-Tilley, 2015). Some mourned the loss of their previous self and what it meant for them, “I mourn the loss of the days that I didn’t have to worry” (Demers, 2013, p.502). In time, participants recognised that strong emotional responses and extreme experiences such as seeing death had changed them in both positive and negative ways (Conard & Scott-Tilley, 2015; Kelly et al., 2014; Suter et al., 2006), which is explored further in the final theme.

Theme 6: Reflection and Reintegration

The final theme outlines how participants managed to gain a sense of reintegration into civilian life. Participants conveyed how their experiences needed to be reflected upon,

processed and articulated to others. They realised they needed to share their stories and for them to be accepted, in contrast to earlier withdrawal which they came to realise had little merit long-term. Reintegration involved personal reflection and seeking belonging in a group where they felt safe to share their stories.

On a personal level, reflecting on the meaning of military service was important for integrating participants' positive and negative experiences. They reflected on their growth as people, their priorities, values, resilience, work ethic, transferrable military skills, strengths and appreciation of life (Burkhart & Hogan, 2015; Negewo-Oda & White, 2011), "to see the world is to know that life gets so much bigger than this little town we live in" (Leslie & Koblinsky, 2017, p116). This helped participants feel it "was worth it" despite the consequences (Leslie & Koblinsky, 2017, p.115). For some, reflection led them towards exploring spirituality and religion, which was then used as a coping resource (Mankowski et al., 2015), "If I had not had some relationship with a higher power, knowing that somebody else is in charge of my life, I probably would be a statistic" (Maung et al., 2017, p73). For some, reflection led them to find ease in accepting and feeling proud of an identity that included many components, and an ability to move between different aspects of the self (Negewo-Oda & White, 2011), "I feel proud of what I did. I feel like being in the military has helped me to be a successful civilian, and I am a veteran" (Burkhart & Hogan, 2015, p.120).

Although some participants in Demer's (2013) study did not want to dwell on their past, generally participants wished to tell their story and feel accepted, "we go around hoping we find the person that can accept the story for what it is, or for what parts we're willing to tell" (Demers, 2013, p.503). One participant found that taking part in the research fulfilled this, "Talking like this felt great; I feel like I've taken a shower. I feel clean." (Demers, 2013, p.504). Others used counselling services to make sense of their emotions (Mankowski et al., 2015; Negewo-Oda & White, 2011), "I couldn't really tell you what I was angry

about…luckily after time and with counselling that resolved" (Maung et al., 2017, p72). Sometimes it was helpful for family members to prompt input with services, due to reluctance to ask for help, "She [sister] noticed what she thought was problems with PTSD. She asked me to seek some help" (Maung et al., 2017, p73). Some expressed that within healthcare it helped to see female professionals with knowledge of military issues, "there has to be a separation and definitely female doctors, who are highly educated on complexities of PTSD and assault and different types of stuff" (Mankowski et al., 2015, p300).

The most common and seemingly favoured strategy for sharing stories was to connect with other female veterans (Burkhart & Hogan, 2015; Leslie & Koblinsky, 2017; Maiocco & Smith, 2016; Mattocks et al., 2012; Maung et al., 2017; Suter et al., 2006). Support from female veterans was valued as participants could be more open, and gained validation and normalisation of their experience by learning that others felt the same, "we could talk about common problems and realise we were not alone" (Maiocco & Smith, 2016, p397). Getting involved in these communities allowed participants to gain social support, but it also allowed them to give it, which gave them a strong sense of purpose and belonging. This sense of supportive comradery could not be matched in any other context, "no-one else talks the language" (Suter et al., 2006, p.12).

Discussion

The aim of this meta-synthesis was to develop a detailed understanding of female veterans' experiences of reintegration. The resulting six themes depicted a process from experiences within the military to reintegration into civilian life (see figure 2). This process is not necessarily linear and there is likely overlap in progression through stages over time. However, themes represent challenges participants described in different aspects of reintegration - from the personal and familial, to broader relational and existential concerns. This review expands on Jones and Hanley's (2017) review of psychological wellbeing post-

deployment by presenting the full journey of reintegration into civilian life after leaving the military, and by incorporating the experiences of female veterans from a non-Western culture (Negewo-Oda & White, 2011).

The first theme outlined experiences of gender discrimination, harassment, MST and combat trauma on deployment, which set context for the extreme emotional aftermath participants described within the second theme. Within the third and fourth themes participants sought to reconnect with those closest to them and civilian life more broadly, which was impacted upon by emotional difficulties that had resulted in withdrawal. Participants needed to readjust to a social context that evolved during their absence, and due to changes within themselves what was previously familiar had become confusing and overwhelming. A thread running throughout the first four themes was feeling fundamentally different to the majority of others around them, and trying to negotiate an identity for themselves where they could fit in. The fifth theme more explicitly addressed the loss of military identity and feeling stuck between the identities of a civilian and veteran. Within the final theme, reintegration was reached when female veterans gained personal and social acceptance of their experiences. Personal reflection helped integrate aspects of strengths and experiences to form a positive sense of identity as a veteran-civilian. Social acceptance was gained through telling their stories and having them accepted. Female veterans were an important resource in this final stage, as the only people who truly understood what they had been through.

The themes indicated key processes in the reintegration journey, however not all participants experienced difficulties within each area. This related to some participants having better access to social support, finding it easier to get a job and coping using active strategies that played on their strengths. It is likely that experiencing trauma and other mental health difficulties made it more difficult for participants to access support, employment and

helpful coping strategies, and therefore made it more difficult to reintegrate. There is a well-documented relationship in veterans' literature between problems with emotions such as PTS and depression, and experiencing a difficult transition from military to civilian life (Carlson, Stromwall, & Lietz, 2013; Morin, 2011; Vogt et al., 2011).

Frequent mention of MST and derogatory treatment across the included studies fits with previous studies highlighting these as significant problems faced by female veterans (Hyun et al., 2009; Woodhead et al., 2012; Zinzow et al., 2007), and emphasised the impact it has on reintegrating with the family post discharge. If the proportion of women in the military is to increase as expected (Department of Veterans Affairs, 2013), it is concerning that MST could be an issue increasing numbers of women face in future. The Ministry of Defence (MoD; 2018) reported that since 2015 military personnel report being more likely to see sexualised behaviour as offensive and to report it. They relate this to a culture shift in the UK from awareness campaigns on sexual assault in the workplace. Recommendations that came from their report are positive, which include web-based anonymous reporting and support systems for service personnel from a minority cohort whilst deployed. It is likely that having an increased female presence in the military will make it easier to implement this.

The current study findings highlighted that female veterans attempted to renegotiate their identity whilst trying to adapt to a change in culture, with different norms, values and expectations than they were used to. During military service participants felt like an outsider as a woman, which they tried to mitigate by becoming more masculine and developing themselves in line with military values. On return to civilian life their military identity then made them an outsider again, as being "toughened up" (Kelly et al., 2014, p.350) had made it hard to connect with family and friends. Participants described compartmentalising their emotions and hiding them so they did not appear weak, which is consistent with the concept of military masculinity within the literature (Hockey, 2003). The impact this has on help-

seeking behaviour has been well documented previously (Simon, 2018; Vogt, 2011), and is supported in the current review where participants described withdrawal as a common way of coping. The current review findings add that female veterans were deterred from talking about problems due to fears they would not be understood or would be judged, which became an additional barrier. Being able to connect with other female veterans was therefore an important resource for sharing stories of the past without fearing judgement. Military masculinity and the veteran-civilian divide will be discussed further within the critical appraisal section of this thesis.

Finally, an important factor that helped participants not just to cope with their difficult experiences but to grow because of them, was to develop themselves in line with a positive military identity. This fits with the concept of post-traumatic growth (Tedeschi & McNally, 2011) within the trauma recovery literature, of which a small portion focuses specifically on veterans (Palmer, Murphy, & Spencer-Harper, 2016). Current review findings suggested that growth was used as a coping strategy whilst in the military, early on in their journeys, as well as emerging later within the processes of reintegrating and renegotiating identity. Tadeschi and McNally (2011) argue that constructive self-disclosure is a way of both gaining support and developing a coherent narrative as part of a healthy trauma response. Participants within the review found it particularly helpful to have contact with female veterans for these reasons. Whilst this was positive, not all participants had this access, highlighting the need for more structured provision of social support for female veterans on discharge from the military.

Clinical Implications

Although none of the included studies were conducted in the UK, findings are relevant and transferrable to female veterans more generally. They demonstrate the need for better awareness of the experiences and needs of female veterans within civilian health

services. Since female veterans may find it difficult to seek help with their mental health, it would be useful if previous military service was identified by general practitioners as part of their registration process on discharge. This would facilitate conversations about mental health and trauma, and could help identify issues early on.

Mental health services need to be prepared for the emotional aftermath and disruption to identity faced by female veterans on leaving the military. Awareness of these issues could be enhanced through training on female veterans' experiences and needs. In this review the specific need for female support was strongly expressed, so providing gender-sensitive support should be a priority in order to give female veterans confidence to speak about their experiences and get the right help. Disseminating the current review findings within healthcare settings would be beneficial.

The findings of this review highlight the need for female veteran support groups, as their therapeutic value cannot be matched within any other setting. Research indicates that being able to fully narrate life experiences can help avert a crisis in identity (Adler & McAdams, 2007), which may help female veterans reintegrate successfully from transition. It is therefore recommended that resources for female veterans within community veteran organisations be more consistently provided. Considering that some participants felt excluded or felt they risked further derogatory treatment within services catering to the needs of male veterans, this is an issue which needs addressing on a structural level. Particularly where community services receive government funding, female veterans need to have confidence that their service and experiences are taken as seriously as their male colleagues.

Research Implications

The MoD (2018) recommended a number of interventions for reducing sexual harassment in the UK military. It is important these interventions be implemented so that effectiveness can be evaluated, in terms of impact on rates of sexual harassment and MST. It

would be useful to compare anonymous reporting rates with official figures, to give information on the extent that MST may have been underreported. The qualitative literature on experiences and consequences of MST is limited in female veterans (Burns, Grindlay, Holt, Manski, & Grossman, 2014) and male veterans (Turchik et al., 2013). Considering the scale of the problem outlined by Wilson (2008), and the support indicated in the current review findings, this is an important area for future research.

There were no qualitative studies related to female veterans' reintegration experiences conducted within the UK and limited papers from other nations than the US. Review findings highlight that reintegration can be a complex process, where experiences during military service have an ongoing impact on female veteran's lives. Exploring experiences of reintegration cross-nationally would be a timely addition to the literature that would strengthen the evidence-base and argument for implementing services and developing interventions to help female veterans with reintegration difficulties.

Strengths and Limitations

Firstly, it is positive that a number of qualitative studies on female veterans' reintegration experiences have been conducted. However outside of the US, studies for inclusion were limited to one study of Ethiopian women (Negewo-Oda & White, 2011). Findings of this study fitted well with the experiences of US female veterans, however the main differences were that Ethiopian veterans reported gender-based derogatory treatment but did not mention MST. They also had to readjust to a female civilian role where they had very limited political influence. Including this study highlighted nuances in military and home cultures that likely impact on reintegration challenges experienced in different cultures, and support rationale for further cross-national research. The similarities in female veterans experiences in the US and Ethiopia do support that the process of reintegration outlined in findings likely applies more widely than the included studies.

Secondly, the researcher was working in a military veteran service whilst conducting the analysis for this review. It is acknowledged that this may have introduced an element of bias to interpretations made. This will be reflected on further in the critical appraisal section.

Conclusion

This meta-synthesis provided insight into the process of reintegration into civilian life for female veterans. The themes derived through analysis outlined ongoing impact of experiences during military service on emotions, family and societal reintegration. Identity needed to be renegotiated from military to veteran-civilian, and this process was disrupted by being within a minority group, first as women within the military, then as a female veteran. Personal reflection and validating social connection allowed female veterans to renegotiate a positive sense of identity, grow as a result of their experiences and successfully reintegrate into civilian life.

The main implications are for more consistent support for female veterans within veteran community service provision, promoting female veteran-specific health issues so services are aware of the needs of this group, and further research into MST and women's reintegration experiences across cultures.

Table 1: Noblit and Hare's (1988) seven steps for meta-synthesis

Steps of synthesis	Summary of actions for each step
Step 1	Getting started – identifying an interest that synthesising qualitative research may inform, forming a research question and searching for literature
Step 2	Deciding what is relevant to the initial interest – setting inclusion and exclusion criteria to decide which articles to include
Step 3	Reading the studies – becoming familiar with the data and identifying the main concepts
Step 4	Determining how studies are related – identifying common or recurring concepts across studies
Step 5	Translating the studies into one another – constantly comparing concepts for similarities and differences, allowing higher abstract concepts to emerge
Step 6	Synthesising translations – suggesting an interpretative order for concepts to build a line of argument
Step 7	Expressing findings of the synthesis

Table 2: Full search terms

Search terms (Combined with AND)	Veteran	Woman	Reintegration	Qualitative
	(veteran* or military or army or navy or “air force” or marine* or forces or “military personnel” or soldier* or servicewom?n)	(wom?n or female*)	(Transition* or adjust* or post-discharge or post-military or retirement or reintegration or "civilian life" or exit or leave* or change*)	(((“semi-structured” or semistructured or unstructured or informal or “in-depth” or indepth or “face-to-face” or structured or guide or guides) N3 (interview* or discussion* or questionnaire*)) or (focus group* or qualitative or ethnograph* or fieldwork or “field work” or narrative or phenomenology* or exploratory or “grounded theory” or thematic or “content analysis” or hermeneutic))
Subject headings by database				
PsycINFO	DE "Military Personnel" OR DE "Air Force Personnel" OR DE "Army Personnel" OR DE "Coast Guard Personnel" OR DE "Commissioned Officers" OR DE "Enlisted Military Personnel" OR DE "Marine Personnel" OR DE "Military Medical Personnel" OR DE "Military Psychologists" OR DE "National Guard Personnel" OR DE "Navy Personnel" OR DE "Volunteer Military Personnel"		Adjustment	Qualitative research
Academic Search Ultimate	Military Personnel		Adjustment (psychology)	Qualitative research
CINALH	Military Personnel		Adjustment (psychology)	Qualitative research

Table 3: Theme construction for theme 1: A woman in a man's world

Key ideas within theme	Article	First order constructs	Second order constructs
High danger, death, trauma	Conard & Scott-Tilley (2015)	Deployment means high danger even if non-combat role	Living in constant fear while deployed
	Burkhart & Hogan (2015)	Experienced 'violence of war' even if non-combat role	Being in the military
	Mattocks et al. (2012)	Combat-related violence experienced and observed	Combat-related experiences
Woman in a man's world	Conard & Scott-Tilley (2015)	Females are outsiders in the military	Disrespect from fellow military members
	Demers (2013)	Woman in man's world - need to blend in	Women at war
	Negewo-Oda & White (2011)	Became a woman soldier - equal to men	Active war roles and challenges
		Woman in man's world	
MST / degrading treatment	Conard & Scott-Tilley (2015)	MST - gender specific stressor on deployment	Combat has different meanings
	Burkhart & Hogan (2015)	Medics experienced less gender specific problems e.g. MST, disrespect	Being a female in the military
		MST frequent (for non-medics) and handled badly when reported	
	Demers (2013)	2 wars - against the enemy and against male colleagues	Women at war
	Mankowski et al. (2015)	Jokes about high ranking women gaining role through intimate relations	Social support while deployed
	Mattocks et al. (2012)	MST is additional to trauma of war	Military sexual trauma
		Derogatory treatment common as well as MST	
	Negewo-Oda & White (2011)	Derogatory treatment based on gender	Active war roles and challenges
Factors that aid coping	Burkhart & Hogan (2015)	Camaraderie / belonging essential to cope	Being in the military
		Developed strong work ethic, leadership, teamwork	
		Response to culture shock was to build self up in line with military values	Adapting to the military
	Mankowski et al. (2015)	Support important while deployed	Social support while deployed
		Fellow female veterans when on deployment helpful	
	Negewo-Oda & White (2011)	Developed confidence during military service	Active war roles and challenges

Note: MST refers to Military Sexual Trauma

Table 4: Theme construction for theme 2: The immediate emotional aftermath

Key ideas within theme	Article	First order constructs	Second order constructs
Mental health, emotions and Post-Traumatic Stress (PTS)	Burkhart & Hogan (2015)	Numbed emotions due to culture shock	Being in the military
		PTS made transition harder - extreme emotions	Experiencing stressors of being a civilian
	Conard & Scott-Tilley (2015)	Emotions - numb or overwhelmed	Bringing the war home
		Intrusive memories of war	
		Trained to be hypervigilant	
	Demers (2013)	Time bomb on the verge of explosion	Coming home
		Cannot un-do military training	
	Maiocco & Smith (2016)	Mixed feelings on coming home	Arriving home with mixed sentiments
		Bring war home - loss, hypervigilance	Remembering war experiences that never end
	Mankowski et al. (2015)	Mental health issues make it harder to adjust	Post-deployment support
		PTS and mental health - need to adjust to wounds and losses	
		Delayed response for some after 'honeymoon period' on arrival home	
	Mattocks et al. (2012)	Lingering effect of war - loss, suicidal thoughts, PTS, depression	Combat-related experiences
		Hypervigilance and nightmares 'a given'	Leaving the war behind
Emotions stigmatising	Mankowski et al. (2015)	Experience tells them to keep quiet about PTS or be discharged	Post-deployment support
	Mattocks et al. (2012)	Shame affected self-advocacy in usually assertive people	Behavioural approach coping strategies
	Maung et al. (2017)	Stigma of mental health issues for soldiers generally - labelled as weak	Stigma
Avoidant coping	Burkhart & Hogan (2015)	Limited coping methods - avoidance and living in the present - served well in military but not civvy life	Experiencing stressors of being a civilian
	Mattocks et al. (2012)	Avoidant coping identified as counterproductive	Behavioural avoidant coping
	Maung et al. (2017)	Substance use to cope with anger and pain	Personal barriers

Table 5: Theme construction for theme 3: An outsider again in one's own home

Key ideas within theme	Article	First order constructs	Second order constructs
Return home	Mankowski et al. (2015)	Reception home important – support and space to adjust	Post-deployment support
		Return home solitary - alone in the experience	
	Negewo-Oda & White (2011)	Leaving military family traumatic for some	Reintegration (post-war) challenges
Intimacy feels strange	Kelly et al. (2014)	Toughened up by the military - hard to be loving and intimate after that	Re-establishing partner connections
	Leslie & Koblinsky (2017)	Intimacy affected by experiencing death and violence	Fear of intimacy
	Maiocco & Smith (2016)	Relationship difficulties masked while away, now come to the fore	Broken relationships
	Mattocks et al. (2012)	Shut off emotions from home life whilst away, hard to switch back	Separation from family
	Maung et al. (2017)	Emotional support and quality time with loved ones helped	Seeking social support
Feel like an outsider	Kelly et al. (2014)	Missed out on children's development / important good times	Being mom again
	Leslie & Koblinsky (2017)	Missed important home stuff – children's development and nice times	Missing children's development
		Conflict with partner and kids over role and discipline	Family role changes
		Anger taken out on family when trivial - then feel guilty	Family members as targets of anger
		Sharing avoided as considered burdensome and may be judged	Sharing vs burdening family members
		Friends and family don't understand / don't want to hear it – which is isolating	Family members lack of understanding of veterans emotional turmoil
	Mattocks et al. (2012)	Sharing vs burden / lack of understanding	Disrupted relationships with family and friends
	Maung et al. (2017)	Useful for family to know about mental health problems and help instigate access to help	Institutional barriers to professional organisations
	Suter et al. (2006)	Civilians, even partner, don't get war experiences – which feels isolating	Experiences of war

Key ideas within theme	Article	First order constructs	Second order constructs
Coping with a change in pace	Demers (2013)	Reintegration into family roles took time	Coming home
	Kelly et al. (2014)	Family role very different to military one - missed military structure	The loss of military role
		Civilian life less regimented and more complicated	Life is more complex
	Leslie & Koblinsky (2017)	Civilian life slow paced at home	Incompatibility of military and civilian pace of life
		Routine and structure restored stability and nurturance	Restoring family rituals and routines
	Mattocks et al. (2012)	Routine and helping others useful to cope	Behavioural approach coping strategies
	Maung et al. (2017)	Needed time to ease back to civilian roles	Using routine activities
		Structure, routine, keeping busy helpful	
Social withdrawal	Demers (2013)	Kept to self but realised this was unhelpful overall	Coming home
	Maiocco & Smith (2016)	Camaraderie essential to cope - lost on discharge and not regained	Permeating aggravation from conversations and actions of others
	Mankowski et al. (2015)	Cannot communicate and ask for what they need	Post-deployment support
	Mattocks et al. (2012)	Withdraw from others and engage in counterproductive coping – e.g. substances, overeating	Cognitive avoidance coping
	Maung et al. (2017)	Avoid and withdraw - aware this blocks support	Personal barriers

Table 6: Theme construction for theme 4: Civvies and civvy systems

Key ideas within theme	Article	First order constructs	Second order constructs
Civilians hard to navigate	Burkhart & Hogan (2015)	Hard to connect with civilians, even old friends	Experiencing stressors of being a civilian
	Kelly et al. (2014)	Civilians trivial and take stuff for granted	Deployment changes you
	Maiocco & Smith (2016)	Civilians trivial which causes anger	Permeating aggravation from others
	Maung et al. (2017)	Think civilians can't understand experiences	Personal barriers
		Don't trust professionals to understand experiences and emotions	Institutional barriers
	Negewo-Oda & White (2011)	Civilians want women to act like women	Reintegration (post-war) challenges
Veteran community focused towards males	Burkhart & Hogan (2015)	Withdrawing, hiding military service and substance abuse	Experiencing stressors of being a civilian
	Demers (2013)	Veteran organisations avoided as don't want contact with male veterans	Coming home
	Suter et al. (2006)	Veterans community often focused towards men	Joining a community of practice
Occupational disadvantage	Burkhart & Hogan (2015)	Civilian workplace challenging - less discipline and commitment	Experiencing stressors of being a civilian
	Conard & Scott-Tilley (2015)	Active service led to physical health problems that limited work	Physical health - for better or worse
Practical system issues	Burkhart & Hogan (2015)	Unprepared for civilian life - finances, work, civilian systems (e.g. health)	Experiencing stressors of being a civilian
	Kelly et al. (2014)	Multiple worries in civvy street - less straightforward	Life is more complex
	Mankowski et al. (2015)	Physical health - complex to sort benefits and medical care	Post-deployment support
	Mattocks et al. (2012)	Finances stressful	Disrupted relationships
	Maung et al. (2017)	Overwhelming to navigate resources available	Institutional barriers
		Finances stressful	
	Negewo-Oda & White (2011)	Reintegration not facilitated by Forces	Reintegration (post-war) challenges
		Women working hard on return, often alone	

Table 7: Theme construction for theme 5: Forever changed and between two worlds

Key ideas within theme	Article	First order constructs	Second order constructs
Between military and civilian identity	Burkhart & Hogan (2015)	Living between two very different worlds - unsure of identity and role	Experiencing stressors of being a civilian
	Demers (2013)	Between two worlds, loss of status depressing	Coming home
	Kelly et al. (2014)	Lost job, lost role, lost purpose	The loss of military role
	Leslie & Koblinsky (2017)	No preparation from military to return to civilian status	Family role changes
	Mankowski et al. (2015)	Wanted to go back	Post-deployment support
		No structure / routine initially, loss of role depressing	
	Negewo-Oda & White (2011)	Some longed for the past	Reintegration (post-war) challenges
		Military role masculine, society role feminine - caught between two worlds	
		Women inferior in political climate at home - big change	
	Suter et al. (2006)	Transition hard, some wanted to return	Transition means loss of identity
		Cling to previous identity	
Forever changed due to experiences	Conard & Scott-Tilley (2015)	Fear of unpredictability of post-traumatic stress and being changed forever	Fear of being forever changed
		Seeing death changes you	
	Demers (2013)	Mourn the loss of previous self	Coming home
	Kelly et al. (2014)	Strong emotional response had positively and negatively changed them	Deployment changes you
	Maiocco & Smith (2016)	Evolving changed view of self and life	Evolving to a changed view of self, family and others
	Negewo-Oda & White (2011)	Preferred fighter identity they developed - can’t go back	Reintegration (post-war) challenges
	Suter et al. (2006)	Changed by military - in good ways and bad	Balanced appraisal

Table 8: Theme construction for theme 6: Reflection and reintegration

Key ideas within theme	Article	First order constructs	Second order constructs
Talking it over	Demers (2013)	Having a safe space to tell story and feel accepted was most important	Coming home
		Some don't want to dwell on the past	
	Mankowski et al. (2015)	Counsellors helpful but not if service focused towards men	Post-deployment support
	Maung et al. (2017)	Counselling and medication helpful	Seeking or gaining professional help
		Family often prompt professional input which is helpful	
	Negewo-Oda & White (2011)	Therapy can assist process of reintegration	Reintegration (post-war) challenges
Community connections	Burkhart & Hogan (2015)	Belonging to veteran-civilian community aided connection	Meaning making of being a veteran-civilian
	Conard & Scott-Tilley (2015)	Experience rewarding despite stress - helping others and forming bonds	Combat has rewarding experiences
	Leslie & Koblinsky (2017)	Support from other female veterans validating, helped self esteem	Accessing veteran support
	Maiocco & Smith (2016)	Contact with other female veterans helpful	Permeating aggravation from others
	Mattocks et al. (2012)	Coming together with female veterans helpful. Male veterans avoided	Behavioural approach coping strategies
	Maung et al. (2017)	Other female veterans easy to talk to - cathartic	Seeking social support
	Suter et al. (2006)	Control of level of engagement with others important	Levels of participation
		Female veterans (old and young) have something to offer each other	Old timers and newcomers
		Comradery and reminiscence helpful	Joining a community of practice

Key ideas within theme	Article	First order constructs	Second order constructs
Reflection and growth	Burkhart & Hogan (2015)	Reflecting on military career meaningful for coping	Meaning making of being a veteran-civilian
		Successfully reintegrated meant proud of being a veteran	
	Leslie & Koblinsky (2017)	Reflecting on meaning of service - priorities, values, independence	Making meaning of military service
		Transferrable military skills - resilience, disciplined, know what matters	Using military acquired skills
	Maiocco & Smith (2016)	Seeking new opportunity, re-evaluating	Seeking opportunity for what is possible
	Mankowski et al. (2015)	Spirituality and religion developed	Post-deployment support
	Maung et al. (2017)	Spirituality and religion used as coping resources	Using aspects of religion/spirituality
	Negewo-Oda & White (2011)	Used strengths from military career	Reintegration (post-war) challenges
		Dual identity possible and helpful	
		Fighter identity symbolically important	

Table 9: Details of included studies

Author/s (date)	Burkhart & Hogan (2015)	Conard & Scott-Tilley (2015)	Demers (2013)	Kelly et al. (2014)	Leslie & Koblinsky (2017)	Maiocco & Smith (2016)
Article title	Being a female veteran: A grounded theory of coping with transitions	The lived experience of female veterans deployed to the Gulf War 2	From death to life: Female veterans, identity, negotiation and reintegration into society	Post-deployment reintegration experiences of female soldiers from National Guard and Reserve Units in the United States	Returning to civilian life: Family reintegration challenges and resilience of women veterans of the Iraq and Afghanistan wars	The experience of women veterans coming back from war
Stated aim	Discover categories and processes in the experiences of women who entered, served in and transitioned out of the military	Discover the experiences of female veterans to understand the impact of combat on physical and mental health	Understand the challenges of reintegration into civilian life and the impact on mental health	Document post-deployment family reintegration experiences of women in the National Guard	Better understand the experience of women veterans as they return to their families and civilian life	Document themes in stories gathered from women veterans coming back from war
Participants	20 females aged 23-65	12 females aged 19-41	17 females aged 22-43	42 females ages 18-58	29 females aged 26-56	8 females aged 24-55
Methodology	Grounded theory	Descriptive phenomenological	Hermeneutic phenomenological	Directed content analysis	Inductive thematic analysis	Content analysis
Data collection method	Interviews in person / by phone	Interviews in person	Focus groups	Interviews in person / by phone	Focus groups	Interviews in person
Location	Illinois, US	Texas, US	California, US	Missouri, US	Maryland, US	West Virginia, US
Journal	Social Work in Mental Health	Nursing Forum	Journal of Humanistic Psychology	Nursing Research	Journal of Family Social Work	Archives of Psychiatric Nursing

Author/s (date)	Mankowski et al. (2015)	Mattocks et al. (2012)	Maung et al. (2017)	Negewo-Oda & White (2011)	Suter et al. (2006)
Article title	Social support throughout the deployment cycle for women veterans returning from Iraq and Afghanistan	Women at war: Understanding how women veterans cope with combat and military sexual trauma	Women in the National Guard: Coping and barriers to care	Identify transformation and reintegration among Ethiopian women war veterans: A feminist analysis	Female veterans identity construction, maintenance and reproduction
Stated aim	Explore social support whilst on deployment and challenges of readjustment to civilian life	Understand how women veterans cope with trauma once they return from deployment	Understand experiences of coping during reintegration into civilian life	Explore gender specific issues tied to women's lives before, during and after the civil war	Explore female veterans identity, construction, maintenance and reproduction
Participants	18 female aged 27-63	19 females aged 23 -55	42 females aged 23-58	20 females aged 36-55	28 females aged 51-91
Methodology	Grounded theory	Constant comparative method	Content analysis	Grounded theory	Qualitative
Data collection method	Interviews in person	Interviews in person	Interviews by phone	Interviews in person	Interviews in person / by phone
Location	West Virginia, USA	Washington, USA	Missouri, USA	Ethiopia	USA
Journal	Social Work in Health Care	Social Sciences & Medicine	Journal of Counselling & Development	Journal of Feminist Family Therapy	Women and Language

Table 10: Results of CASP assessment with total CASP score

Article	Screening questions: (1) Aims clearly stated? (2) Qualitative method appropriate?	Did the research design address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Total CASP score (out of 24)
Burkhart & Hogan (2015)	Yes	2	2	3	2	2	2	3	3	19
Conard & Scott-Tilley (2015)	Yes	3	2	2	3	3	3	3	2	20
Demers (2013)	Yes	3	2	3	2	2	3	3	3	21
Kelly et al. (2014)	Yes	1	3	3	2	3	3	3	2	20
Leslie & Koblinsky (2017)	Yes	1	3	3	2	2	3	2	3	19
Maiocco & Smith (2016)	Yes	2	1	2	2	2	2	2	3	16

Article	Screening questions: (1) Aims clearly stated? (2) Qualitative method appropriate?	Did the research design address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Total CASP score (out of 24)
Mankowski et al. (2015)	Yes	1	3	2	2	1	2	3	2	16
Mattocks et al. (2012)	Yes	1	1	2	2	3	2	3	2	16
Maung et al. (2017)	Yes	2	2	2	2	2	3	3	3	19
Negewo-Oda & White (2011)	Yes	1	3	2	3	1	2	2	2	16
Suter et al. (2006)	Yes	1	2	3	2	1	2	2	3	16

Figure 1: PRISMA diagram outlining search results

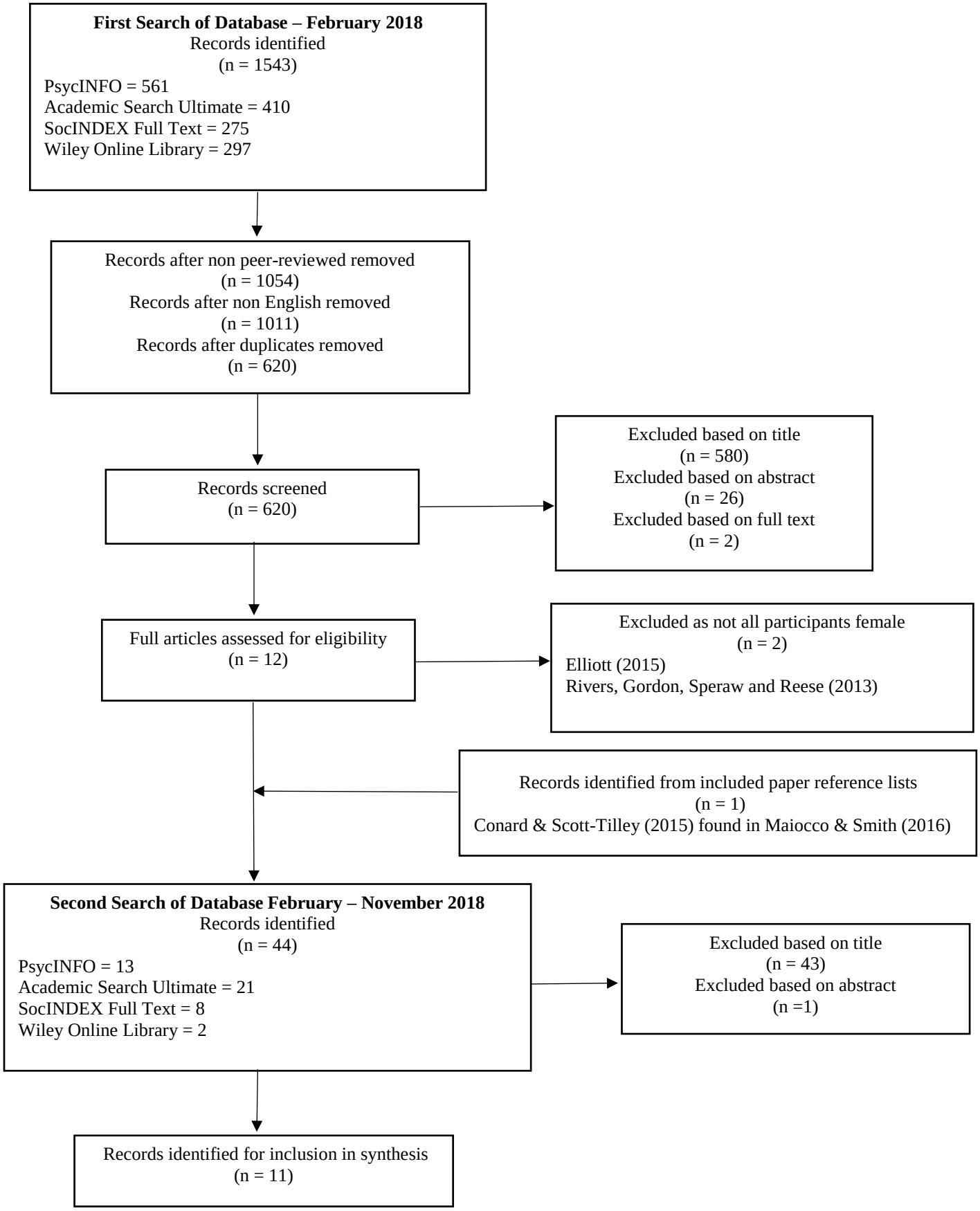
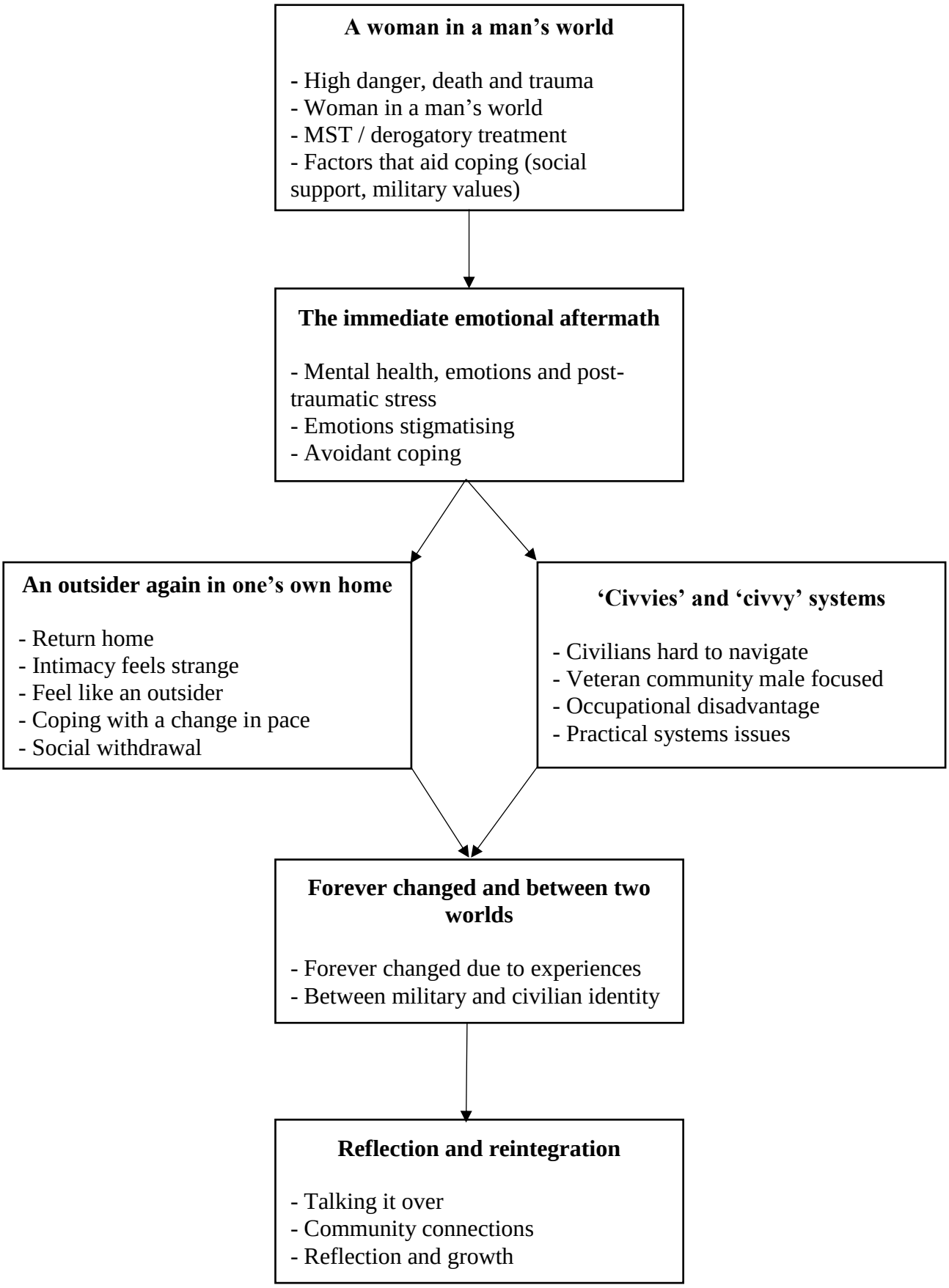


Figure 2: Visual representation of themes and key concepts



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Appendix 1: Author Guidelines

Armed Forces & Society

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SUBMISSION GUIDANCE

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ALL MANUSCRIPTS MUST BE SUBMITTED IN APA 6TH EDITION CITATION STYLE

Armed Forces & Society has completed its transition to APA 6th Edition citation style. We apologize for any inconvenience, however we believe this will dramatically improve the impact of our author's articles. You may find our modified APA guidelines below:

Manuscript Guidelines

Manuscripts should be submitted electronically to http://mc.manuscriptcentral.com/afs where authors will be required to set up an online account on the SageTrack system powered by ScholarOne. Submission of a manuscript implies a commitment by the author to publish in the journal, if the manuscript is accepted; authors must certify that the manuscript is not currently under consideration by any other journal.

Ordinarily, manuscripts should not exceed 26 pages and 8,000 words, including tables, figures, and references. Manuscripts received which are significantly higher than the limit will be automatically rejected. Manuscripts are subjected to blind peer review and thus it should be anonymized. The author's names and self-citations should be removed or blacked out. Any other identification, including any references in the manuscript, the notes, the title, and reference sections should be removed from the paper and listed on separate pages, e.g., title page.

Manuscript Preparation and Submission

Manuscripts should be prepared using the APA Style Guide (Sixth Edition). All pages must be typed, double-spaces. The body of the manuscript must be in 12-point Times Roman. Block quotes should be single-spaced and indented. The margins should be 1 inch on all the four sides. Please omit running head and any header/footer entries. Reference and endnote pages should be 10.5 point font with 1.5 line spacing.

Submission Should Contain Three Files

The manuscript should include three major sections (in this order): Title Page with abstract, Main Body, and References. Manuscript features should appear in this order:

- Title page
  - Full article title
  - Abstract (maximum 150 words)
  - Author(s) Biography (no more than 50 words)
  - Each author's complete name and institutional affiliation(s)
  - Acknowledgments and credits
  - Grant numbers and/or funding information o Corresponding author (name, address, phone/fax, e-mail)
- Manuscript
  - Pg 1 contents:
    - Title
    - Abstract
  - Text (should begin on new page)
  - Tables (should begin on new page)
    - Tables should be structured according to APA Guidelines. Each table must have a clear and concise title.
    - When appropriate, use the title to explain an abbreviation parenthetically. Eg. Comparison of Median Income of Adopted Children (AC) v. Foster Children (FC).
  - Figures. (should begin on new page)
    - Figures should be numbered consecutively in the order in which they appear in the text and must include figure captions.
    - Figures will appear in the published article in the order in which they are numbered initially.
    - The figure resolution should be 300dpi at the time of submission.
  - References (should begin on new page)
  - End Notes (should begin on new page)
- Appendices
  - Appendices which may be referenced in the manuscript, should appear in a separate document unless they are intended to be published with the article, if it is accepted. Otherwise, appendices shall be published online as a supplement to the article.
  - Appendices should be lettered to distinguish from numbered tables and figures. Include a descriptive title for each appendix (e.g., "Appendix A. Variable Names and Definitions"). Cross-check text for accuracy against appendices

Manuscript Heading Design

Headings and subheadings

Headings and subheadings should be clear and brief. Headings should indicate the organization of the content of the section. Generally, three heading levels are sufficient to organize text; however, APA provides for five levels. They should be formatted as follows…

First Level Headings, Centered, Bold, Title Case

Second Level Headings, Flush Left, Bold, Title Case

Third level headings, bold sentence that begins a paragraph and ends with a period. The text then immediately follows after.

Fourth level headings, italicized sentence that begins a paragraph and ends with a period. The text then immediately follows after.

Fifth level headings, sentences that begin a paragraph and end with a period. The text then immediately follows after.

Citations

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For each text citation there must be a corresponding citation in the reference list and for each reference list citation there must be a corresponding text citation. Each corresponding citation must have identical spelling and year. Each text citation must include at least two pieces of information, author(s) and year of publication.

End Notes

If explanatory endnotes are required for your manuscript, please use Microsoft Word's Insert Footnote feature under the Reference ribbon.. The Footnotes should be added at the bottom of the page after the references. The word "Notes" should be centered at the top of the page.

References

Basic rules for the reference list:

- The reference list should be arranged in alphabetical order according to the authors' last names;
- If there is more than one work by the same author, order them according to their publication date – oldest to newest (therefore a 2008 publication would appear before a 2009 publication);
- When listing multiple authors of a source use "&" instead of "and";
- Capitalize only the first word of the title and of the subtitle, if there are one, and any proper names – i. e. only those words that are normally capitalized;
- Italicize the title of the book, the title of the journal/serial and the title of the web document;
- Manuscripts submitted to Armed Forces & Society (AF&S) should strictly follow the APA manual (6th edition);
- Every in-text citation must have the detailed reference in the Reference section;
- Every reference listed in the Reference section must be cited in text;
- Do not use "et al." in the Reference list at the end; names of all authors of a publication should be listed there.

Examples Of Commonly Found References

For more examples please check APA (6th ed).

Periodicals. Note that all periodicals must include a DOI if they are not yet assigned to an issue.

Journal article with one author
Smith, A. (2015). Effects of Multiple Deployments on Families and Unit Readiness. *Armed Forces & Society, 13*(6), 578-583.

Journal article with more than one author, but less than 8
Gabbett, T., Jenkins, D., & Abernethy, B. (2010). Physical collisions and injury during professional rugby league skills training. *Journal of Science and Medicine in Sport, 13*(6), 578-583.

Journal article – 8 or more authors
Crooks, C., Ameratunga, R., Brewerton, M., Torok, M., Buetow, S., Brothers, S., … Jorgensen, P. (2010). Adverse reactions to food in New Zealand children aged 0-5 years. *New Zealand Medical Journal, 123*(1327). DOI: xx-xx-xxx-xxxxxx2343.

Conference Paper
Williams, J., & Seary, K. (2010). Bridging the divide: Scaffolding the learning experiences of the mature age student. In J. Terrell (Ed.), *Making the links: Learning, teaching and high quality student outcomes*. Proceedings of the 9th Conference of the New Zealand Association of Bridging Educators (pp. 104-116). Wellington, New Zealand.

Podcast (audio or video)
Rozaieski, B. (2011). Logan cabinet shoppe: *Episode 37: Entertainment center molding* [Video podcast]. Retrieved from http://blip.tv/xxx

Thesis (online)
Mann, D. L. (2010). V*ision and expertise for interceptive actions in sport* (Doctoral dissertation, The University of New South Wales, Sydney, Australia). Retrieved from http://handle.unsw.edu.au/1959.4/44704

Books

Book with place of publication
Airey, D. (2010). *Logo design love: A guide to creating iconic brand identities*. Berkeley, CA: New Riders.

Book with editors & edition
Collins, C., & Jackson, S. (Eds.). (2007). *Sport in Aotearoa/New Zealand society* (2nd ed.). South Melbourne, Australia: Thomson.

Book with author & publisher are the same
MidCentral District Health Board. (2008). *District annual plan 2008/09*. Palmerston North, New Zealand: Author.

Chapter in an edited book
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Section Two: Empirical Study

An Interpretative Phenomenological Analysis of Veterans' Experiences of Successfully Managing Post-Traumatic Stress

Title Page

Full Article Title

An interpretative phenomenological analysis of veterans' experiences of successfully managing post-traumatic stress

Abstract

Quantitative studies dominate the research literature on post-traumatic stress in Veterans. Whilst this has been helpful in establishing prevalence, barriers to help-seeking and potential consequences of post-traumatic stress, qualitative research into veteran's views and experiences of successfully managing post-traumatic stress is highly relevant to understanding how best to support them. This study explored six veteran's experiences through semi-structured interviews. Interpretative phenomenological analysis was used to understand the data, from which three themes were drawn: (1) accepting the problem, taking responsibility and gaining control, (2) talking to the right people, and (3) strategies, antidotes and circling back around. Implications for research and practice included increasing opportunities for peer support from other veterans, providing education to civilian health services on veteran's needs and community resources, and forming better links between community support agencies and health services.

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An Interpretative Phenomenological Analysis of Veterans' Experiences of Successfully Managing Post-Traumatic Stress

Quantitative studies dominate the research literature on post-traumatic stress in veterans. Whilst this has been helpful in establishing prevalence, barriers to help-seeking and potential consequences of post-traumatic stress, qualitative research into veteran's views and experiences of successfully managing post-traumatic stress is highly relevant to understanding how best to support them. This study explored six veteran's experiences through semi-structured interviews. Interpretative phenomenological analysis was used to understand the data, from which three themes were drawn: (1) accepting the problem, taking responsibility and gaining control, (2) talking to the right people, and (3) strategies, antidotes and circling back around. Implications for research and practice included increasing opportunities for peer support from other veterans, providing education to civilian health services on veteran's needs and community resources, and forming better links between community support agencies and health services.

Post-Traumatic Stress (PTS) describes the biopsychosocial aftermath of "a stressful event or situation of an exceptionally threatening or catastrophic nature" (National Institute for Health and Care Excellence, 2018, p.43), characterised by re-experiencing the traumatic situation/s, avoiding reminders, hypervigilance and overwhelming or numbed emotions. PTS resolves without intervention for most people, however for some it persists or worsens, or its onset is delayed (Bonanno & Mancini, 2012). Since the third edition of the Diagnostic and Statistical Manual (American Psychiatric Association, 1980), psychiatry has conceptualised enduring and problematic PTS as Post-Traumatic Stress Disorder (PTSD). This diagnosis will apply to some who experience PTS, however not everyone who experiences mental health difficulties presents to mental health services seeking a diagnosis (Kim, Britt, Klocko, Riviere, & Adler, 2011). As this article aims to promote a psychological rather than biomedical understanding of trauma, the term PTS will be favoured.

In the United Kingdom (UK) a veteran describes anyone who has served at least one day in the military (Burdett et al., 2013). Trauma in veterans has become an international topic of interest, related to factors that make PTS a particular problem for this group. Overall prevalence is difficult to estimate as data has not been collected in a routine, standardised way across military organisations over time, making comparing data potentially misleading. In the UK, Stevelink et al. (2018) conducted a phased military cohort study from 2006 to 2016 tracking impact of Operation's Enduring Freedom and Iraqi Freedom on mental health of personnel. They found that prevalence with a 'probable PTSD diagnosis' rose from 4% to 6% during this period. Prevalence in the general UK population is estimated at 3% (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009). United States (US) prevalence estimates for the same conflicts range from 6-41%, with a meta-analysis by Fulton et al. (2015) concluding overall prevalence of 23%. There is clearly a big difference between the

UK and US figures, although sampling methods, such as recruiting within a veteran's healthcare setting, may explain some variability.

In addition to prevalence figures, the military context is relevant to understanding why PTS is problematic for veterans. Compared to average civilians, military personnel deployed in active conflicts experience high exposure to extreme situations of danger, violence and death, regardless of role (Conard & Scott-Tilley, 2015). Regrettably "the psychological toll of war is very heavy" (Sher, 2009, p.921), however dealing with the emotional consequences is not prioritised. In fact military training aims to socialize recruits into "an idealised culture of warrior masculinity" (Shields, 2016, p.64) where collective identity and social status are based on displays of traditionally masculine traits, like remaining strong and stoic in the face of extreme adversity (Hockey, 2003). Furthermore, there is a long history of stigma around combat stress reactions, previously depicted as indicating weakness or cowardice (Shields, 2016). Although this is no longer explicitly endorsed, Whitworth (2008) commented that the military sees PTS as a subversion from military masculinity that it cannot easily accommodate, so the problem is minimised on a collective level and individuals hide their difficulties. Military masculinity seems to remain embedded post-discharge, with veterans reporting emotional difficulties as shameful, and a challenge to their identity, strength and power (Cornish, Thys, Vogel, & Wade, 2014). These factors decrease likelihood veterans will seek help to manage PTS, isolating them with their problems (Shields, 2016).

In regards to consequences of PTS, firstly it affects how difficult veterans perceive their transition from military to civilian life (Morin, 2011). Contributing to these difficulties may be increased problems with other aspects of health commonly reported by veterans with PTS, such as depression and alcohol misuse (Kaysen et al., 2014; Stander, Thomsen, & Highfill-McRoy, 2014), and increased physical health symptoms (Baker et al., 2009).

Together these factors likely impact on daily functioning and ability to retain employment, leading to loss of identity, purpose and independence. Furthermore, difficulties in relationships more frequently arise due to aspects of PTS such as emotional numbing, withdrawal, anger, and coping through avoidant means, such as alcohol misuse (Ray & Vanstone, 2009). Alcohol misuse has been linked to aggressive behaviour in PTS, as it decreases processing capacity and increases disinhibition, making it more likely hypervigilance to threat will be activated into a fight response (Taft et al., 2007). Karney, Ramchand, Osilla, Caldarone and Burns (2008) theorised that the immediate consequences of PTS described above can lead to a 'cascade' of further negative long-term outcomes which lead veterans to become increasingly excluded from society. This includes family breakdown, homelessness, violence, entering the criminal justice system and ultimately suicide (Karney et al., 2008; Thompson, 2010).

Unfortunately, despite the magnitude of some veteran's difficulties, they have reported encountering barriers to accessing help through civilian mental health services (Kim et al., 2011). Factors contributing to this are stigma, discomfort attending busy community venues, low perceived understanding of military culture in professionals, and exclusion due to alcohol dependency or involvement in the criminal justice system (Bunnell et al., 2017). In response to these difficulties, much research has focused on barriers to help seeking (Murphy, Hunt, Luzon & Greenberg, 2014). In comparison, research into how veterans learn to manage PTS, with or without service input, and how they conceptualise successful management has been overlooked. It is important to address this, as these factors likely influence the kind of support to offer veterans to better engage them in services.

Recovery in mental health is a contested concept with ambiguous meaning. It likely describes a process or personal journey rather than an outcome (Roberts, 2008), and has a broader focus than just resolving symptoms of a diagnosis (Craig, 2008). However, within

mental health services, recovery from PTS in adults is mainly conceptualised through decreased scores on quantitative measures based on symptoms of PTSD (Giebel, Clarkson, & Challis, 2014). Reducing complex experiences to numerical outcomes risks creating disconnection between those who provide services and those who actually experience PTS. It is therefore important to supplement quantitative data collection with qualitative data, and it has been identified that there is a paucity of research in this area (Palmer, Murphy, & Spencer-Harper, 2017). Due to ambiguity surrounding whether one can recover from PTS and how such recovery would be defined, this study will instead focus on experiences of 'successfully managing' to denote progress which has been made rather than reaching a fixed end point.

Within the small existing qualitative literature asking veterans what helps successfully manage PTS, a study of Portuguese war veterans (Farrajao & Oliveira, 2014) highlighted the importance of increased self-awareness, building coping strategies and using social support. In contrast, feeling betrayed by the military, judged by society and depleted in personal resources were barriers to moving past traumatic experiences. A further area focused on in the literature is post-traumatic growth (PTG; see Tedeschi & Calhoun, 1995), where hardships endured result in a perceived level of self-actualisation and appreciation of life that goes beyond the pre-trauma state. For instance, Palmer et al. (2017) found that some veterans reported positive changes resulting from trauma, including changed perspectives of negative events and emotions, increased appreciation of the world around them and improved connections with others. Although PTG has been connected with reduced symptoms of PTS previously (Zoellner & Maercker, 2006), it remains unclear whether this is a necessary aspect of successful management or if it is just one approach veterans may take (Tedeschi & McNally, 2011). Further qualitative enquiry into the full journey of managing PTS is certainly needed to build a more complete understanding of this complex phenomenon. This

makes a qualitative study in this area a timely addition, and forms the rationale for this study. The study aim was thus to gain a detailed understanding of how veterans see successful management of PTS, and what has helped them in their journey towards this.

Method

Design

A focus group was conducted with veterans from a local community organisation prior to setting the research question, to request their views on what it was important for the research to focus on. Their feedback recommended that research document successes in managing PTS to help other veterans and enable civilians/professionals to understand veterans better, which fitted well with the gap in the qualitative literature identified above. The research question was thus set as 'what helps veterans to successfully manage post-traumatic stress?' A qualitative design allowed for detailed exploration of this issue. Interpretative Phenomenological Analysis (IPA) was the chosen method, due to its core focus on the subjective reality of the person experiencing a phenomenon (Smith & Eatough, 2006). IPA allows researchers to gain an 'insider's perspective' (Conrad, 1987) into how a person from a unique group makes sense of their experience. This requires a "double hermeneutic" (Smith & Osborn, 2003, p.51), where researchers make sense of the sense made by participants. IPA allows in-depth case-by-case idiographic exploration of complex phenomena, making it suited to a small sample size (Eatough & Smith, 2008). The research was undertaken from a critical realist standpoint, assuming that similarities arising across individual accounts allow broader knowledge to be gained about how PTS can be successfully managed in veterans.

Participants

Recruitment. Purposive sampling was used to recruit veterans with experience of managing PTS, by attending veterans' community organisations in the North West of

England to inform veterans about the study and provide expression of interest forms with brief details and inclusion criteria.

Inclusion criteria. Participants were veterans from any branch of the military, with any job role. They identified with PTS related to their military service and had experience of managing it such that they could report what had been helpful. Criteria was confirmed on contacting participants who expressed interest. Participants spoke English and were UK residents. Civilians and veterans without experience of managing PTS were excluded.

Sample. Six veterans participated, five male, one female, from the British Army (n=4) and Navy (n=2). Five participants were diagnosed with PTSD, and one with adjustment disorder, but reported experiencing symptoms of PTS. Participant demographic information is displayed in table 1, which outlines pseudonyms given to protect anonymity.

Consent. Participants who indicated interest were given a participant information sheet outlining full study details and at least 24 hours to consider the information before deciding to take part. Interviews were then arranged, at which point participants provided written consent. The researcher explained that interviews could be terminated any time and breaks could be taken if helpful.

Ethics. Lancaster University's Faculty of Health and Medicine Research Ethics Committee (FHMREC) reviewed and approved the study.

Data Collection

Participants were briefed that they would not be asked about their traumatic experiences but about their experience of managing PTS, and to share what they saw as most important and felt comfortable discussing. Interviews followed a semi-structured interview schedule (see p4-30), keeping questions open and initially broad. The researcher modified questions based on what participants expressed as most meaningful. Interviews happened in

person at community venues, facilitated by recruiting organisations, lasting between 65-120 minutes, and were audio recorded and transcribed verbatim.

Data Analysis

The researcher used IPA as outlined by Smith, Flowers and Larkin (2009). This involved becoming immersed in the data by reading and re-reading transcripts, initially whilst listening to the interview recordings. Whilst reading, exploratory notes were made on the transcript commenting on participants' descriptions of phenomena, language used and meaning attributed to experiences. These notes were used as the basis for the next stage of analysis, which involved reducing data to key ideas interpreted to be important. This was done for each participant's transcript, resulting in a set of emergent themes. Emergent themes were then compared across participants for connections, differences, exceptions and broader abstract concepts arising across the data. Superordinate themes were developed as a result of this process. A narrative summary was produced for each participant outlining how data contributed to each superordinate theme.

Reflexivity

In IPA the researcher has an active interpretative role in analysing meaning participants ascribe to phenomena, so the researcher's own views and assumptions inevitably influence the analysis outcome. The researcher was working on placement in a military veterans' service whilst conducting the study, which may have additionally influenced interpretations made. To allow views and assumptions to become more conscious a reflective journal was used throughout data collection and analysis, helping ensure interpretations were grounded in the data rather than personal experiences or opinions. To ensure transparency of the analysis process, the researcher provides examples of initial comments and emergent themes from an interview transcript (table 2), how participant emergent themes mapped on to superordinate themes created (table 3) and narrative summaries of overarching themes for

one participant (table 4). The researcher regularly met with a research supervisor throughout the project, sharing and discussing the recording of the first interview, examples of commentary, emergent themes and superordinate themes. Extracts of participants' accounts are presented throughout the analysis to support the interpretations made.

Findings

Three themes were developed through the process of analysis, 'accepting the problem, taking responsibility and gaining control', 'talking to the right people' and 'strategies, antidotes and circling back around'. Figure 1 provides a visual representation of themes and key concepts.

When asked about their experience of PTS all participants outlined symptoms they had experienced, which included hypervigilance, avoidance, nightmares, flashbacks, anxiety and anger. Danny and Jackson reported having dissociative episodes, and Danny an additional diagnosis of personality disorder. Stan was diagnosed with adjustment disorder, but felt his difficulties were "more military related" than mental health services recognised. Participants talked about the impact of PTS on transition and their lives subsequently, describing conflict within the family and civilian community, difficulty maintaining employment and losing their sense of identity and purpose. All participants were operationally deployed at least once, and experienced unplanned discharge from the military; four due to physical injury or illness, and two as family members insisted that they leave.

Theme 1: Accepting the Problem, Taking Responsibility and Gaining Control

The first theme integrates participants' reflections on the process of accepting their difficulties with PTS, from initial denial and lack of awareness, to taking responsibility and gaining control over PTS. Life events perceived as 'changing points' in this process altered how participants saw their difficulties and coping mechanisms. The level of control

participants felt they had differed, with two participants perceiving less control of PTS and reporting taking less responsibility for their actions.

First, to set context, participants' initial response to their emotions on discharge was described as the military way of coping, which was to hide their pain from themselves and others, and thus avoid feeling weak. However, minimising strong and confusing emotions was ineffective at reducing their intensity or impact, and over time they grew more problematic,

> Because it took me so long to admit I had a problem, it got deeper and deeper so it was harder and harder to, it took a lot longer, it's taken me years to get to the point of where I am now (Danny).

Not acknowledging the problem and hence not talking about it meant "the abnormal had become normal" (Jackson), and most participants did not acknowledge destructive coping mechanisms, such as excessive drinking and self-harm. Complicating matters was participants' unplanned discharge from the military, as subsequent lack of closure on their service made it difficult to integrate back into civilian life,

> There was no debrief or de-erm what's the word, of your mind. There was no change or 'right, you're leaving one situation and going into another, and the two are completely different'….The mind is caught somewhere in between (Stan).

Stan added that the military offered little resettlement, echoing resentment also expressed by others, "Resettlement is the key word here. We never got any. That adds to that chip on the shoulder. The fact that I came out for the wrong reasons and it's been nothing but a bloody struggle after" (Terry). Loss of military identity and structure led participants to feel depressed, most emphatically expressed by participants with severe physical injuries, "I thought 'is this it now?'" (Craig).

Participants' narratives indicated being stuck in a downward spiral and feeling out of control, which continued until it reached what Terry described as a "big crescendo", a point where they could no longer deny their difficulties. Conflicts with loved ones, breakdown of

the family and being unable to work left participants “at rock bottom” (Lauren) with four reporting that they considered suicide. The meaning taken from this low point is encapsulated by Danny, “it made me realise that I needed to do something about it or I'm just going to be another statistic”, a sentiment echoed by Craig, who felt “saved” from suicide. Participants entered mental health services at this point, initially persuaded by family members or friends due to resistance to talking about problems.

Mental health services provided an explanation for what participants were experiencing, allowing them to appreciate connections with past events and circumstances, and reconsider beliefs that experiencing emotional difficulties made them “weak” (Craig) or “effeminate” (Jackson). This made it easier to accept what they were experiencing and take more responsibility for their emotions and actions, to gain a sense of control, “I stopped saying why me, and more like, well for whatever reason I'm going through this, I need to do something about it. I convinced myself I would learn other coping strategies and use those to combat the symptoms” (Danny). Participants described coming to a balanced view of PTS by learning more about it, acknowledging that they could cope with rather than cure it,

> I have learned a lot from it, a lot of coping strategies, and now I think I'm in control of my own life. I still have issues and problems, but I will do for the rest of my life. I have accepted that. And I've got a lot of things to look forward to (Terry).

It was notable that Lauren’s and Stan’s narratives contrasted with other participants in the lack of control they felt they had, with this quote by Stan indicating that he felt PTS had control over his life,

> It’s like a never-ending circle. And I feel like that’s going to go on for the rest of my life now. I am never, no matter what type of treatment I have, ever going to get out of that cycle.

This seemed related to instances where they were not able to respond differently in situations that triggered anger, which they both justified by saying that others were at fault on that occasion, “seems to be a common thing with PTSD, we seem to get aggravated because

people realise they can trigger us to get angry" (Lauren). This suggested that for Lauren and Stan the lack of responsibility they took for their behaviour was connected to perceiving less control of PTS.

Theme 2: Talking to the Right People

While the first theme focused on personal acceptance of PTS in order to take responsibility and gain control, the second outlines how participants attempted to gain social acceptance and support for managing their difficulties. There was consensus that talking about problems was necessary for releasing and managing emotions, but this was conditional on "talking to the right people" (Terry). This theme offers insight into what talking to the right people meant for them.

Participants demonstrated an overwhelming preference for speaking to veterans about their difficulties, "being able to talk to guys that were similar to me, that was huge" (Stan). They assumed veterans would naturally understand and accept their experiences due to familiarity with the military context, meaning veteran groups had a family-like atmosphere where they felt confident to speak without judgement, "I am not the only person having this problem. So if they are able to talk about it, then probably I might as well start talking about it" (Jackson). In contrast to formal one-to-one relationships with professionals in mental health services, the familiar, relaxed and informal nature of contact with veterans made it easier to open up, "it was a different surrounding. It wasn't questions and answers, we were having a cup of coffee, feet up, chilling out, bit of music, and just started talking about it" (Danny). The consistency of support from the veteran community allowed trust to build over time and for sharing to be comfortably paced. Hearing other veterans' stories helped participants continue to challenge internally held views that expressing emotions was weak, and military banter was used as a resource for "turning crying into laughter" (Craig) when emotions became too intense.

Some participants stated a preference for seeing ex-military doctors after having negative experiences within civilian healthcare. Danny offered an explanation,

> Our understanding of doctors in the army is medics, so we go to medics for various problems, mental as well. So we don't see GPs, so it's not the GPs' fault but then they have not built that understanding. That's a big problem. It's the same with mental health services. A squaddie would rather have someone from the military to talk to because of the understanding of what it's like to be a soldier.

The majority of the therapists participants saw were civilians, but they noted a difference in interest and understanding of military context in generic versus veteran-specific mental health services. When therapists understood the context participants felt more able to relate to them, which was considered calming and essential for benefitting from therapy. Where therapists had no appreciation of military culture they risked being perceived as insensitive or intrusive. Terry compared his therapist from generic and veteran-specific services to illustrate how communication styles differed,

> He said 'I've got to ask you, have you got any violent tendencies today' I said 'well no'....So that put me on my guard straight away. I never understood that, that it was how we would sort of start off. He kept going on as well about things that I'd witnessed, but do you really want to be reminded? Whereas she, we used to talk about all sorts, but she would very craftily say, although we were talking in general there was questions but I wouldn't realise until afterwards.

Two participants contrasted relaxed and patient practitioners with others where they felt "interfered with" or "rushed", meaning they could not discuss everything they wanted and consequently, "you go out feeling foolish" (Craig). Continuity of support was very important where difficulties were complex as once "un-bottled" (Terry) participants wanted help managing the strong emotions that resulted, making generic mental health services limited in what they could offer. Jackson felt that the therapist's personal qualities were also important, "you have to take a psychologist who is patient and understands your needs…who you can trust, and who accepts you as you come today…I believe not every psychologist has got that, to do it" (Jackson).

Some participants appreciated “straight-talking” advice by people they could trust that they could immediately act on, “I’ll do it because someone told me to do it” (Craig). This included “talking through what to do differently next time” (Terry) and being strictly instructed to stop harmful and ineffective coping strategies.

Lauren and Terry reported difficulty accessing continuous psychological support due to physical health conditions taking priority for treatment. The lack of integration within health services led Lauren to say “my doctors don’t care” and she felt she was too complex to access mental health support. In contrast, Jackson’s physical health difficulties were accommodated by his therapist, whose small adjustments made it possible for him to benefit from having the long-term input he felt he needed.

The worst experiences communicating their difficulties participants reported were with civilians within their communities. Although social acceptance was not stated as necessary for managing symptoms, three participants said that stressful interactions with civilians made managing PTS more difficult. All participants saw a fundamental divide between themselves and civilians due to their military experiences and training,

> I remember saying something about bloody civvies and this guy said 'you're a civvy', I said 'no I'm not' and like it’s hard to accept that you're a civvy now. Because you're not desensitised to the military way of life before you come out (Lauren).

Frustrations included civilians having “no sense” (Stan), “no logic” (Terry) and “protocols that don’t mean anything” (Lauren), indicating a struggle to navigate civilian systems that lacked the order and efficiency of the military. Civilians were perceived to focus too much time and energy on trivial matters, “there is stuff happening to women out there, there's children being raped, people being murdered, wars going on and you’re complaining about a dustbin. Get a life” (Lauren). They felt civilians generally did not acknowledge their military experience or respect them for what they had endured, resulting in them feeling alienated and misunderstood. When civilians did ask about their experiences, some felt it was done in an

insensitive, judgemental way, “they think you shoot somebody every day” (Terry). Frustrations extended to civilian organisations, (e.g. government and local councils), who some participants did not feel could provide them with adequate practical support as they did not understand PTS or the military context. In contrast, one participant praised his local council for having an ex-forces liaison officer who provided face-to-face support and organised activities for veterans. The inconsistency in services across areas led Terry to view the Armed Forces Covenant as a “rubber stamp activity”, commenting “you've served your country now let your country serve you. That hasn’t applied to me”.

Danny and Craig reported less difficulty with civilians and more contact with mixed civilian-veteran groups, through community outreach projects within veterans’ organisations they were involved in. They were positive about this contact, with Danny enjoying how civilians came to understand the “military banter”. Danny had also talked to school children about his experiences and reported being comfortable answering their direct questions about war and killing people. Less judgement seemed to be perceived in their childish curiosity than in strong opinions on morality of war Danny encountered in some adult civilians.

Theme 3: Strategies, Antidotes and Circling Back Around

This theme represents what most helped participants actively manage PTS, which was described as following on from personal acceptance and talking to the right people. The theme describes how participants managed PTS within the context of negotiating new identities for themselves over time, integrating aspects of their military identity that remained important to them, and challenging the more problematic parts, thus opening up new ways of expressing and managing emotions. Most participants described ‘circling back around’ to the veteran community, where they further rebuilt their identity through renewed belonging and helping other veterans. Participants felt efforts to manage PTS had a positive impact, which

for them meant symptoms happened less often, for a shorter duration and did not seem as intense.

Participants recognised they could not always predict when symptoms would be triggered, but they could draw from their military strengths to be prepared by putting together and practising strategies that worked for them, “because in the forces you know what you're doing all the time” (Stan). It was clear that managing PTS was a long-term process that took time and perseverance,

> It is not a one-day fix but a process. I will say it was very difficult because it was like I was being taught, like a baby to speak again...it is very difficult to do because you have to train your mind, so it took a long time (Jackson).

Participants adopted a structured routine to create stability in their lives, and some included within this meticulous record-keeping to mitigate memory difficulties associated with PTS, allowing them to “shift the burden to the system” (Jackson). Participants needed to adjust expectations of themselves so that they did not plan to do more than they could manage and inadvertently cause themselves extra stress, for instance by working part-time rather than full-time.

For a strategy to be considered helpful participants needed to be able to do it frequently without it becoming destructive or ineffective (i.e. like avoidance), as once they saw it worked they were motivated to repeat it. They reported discovering helpful coping strategies mainly through mental health services, which helped them become more present in what they were doing. This could be incorporated in to their daily activity to have a calming effect and bring them out of negative thoughts and ruminations,

> My gardening, because you’re not deliberately thinking something. That’s why I like to get stuck into my gardening, even though sometimes I look like I'm digging sand not soil, I just stop and smell this leaf or the disinfectant and think, 'you're gardening'...I always talk to myself when I'm gardening (Lauren).

Lauren’s use of her senses and self-talk were strategies frequently mentioned by other participants also, which were referred to as ways to ground themselves in the present

moment, to give a temporary but strong calming effect during times of acute anxiety or anger. Lauren and Jackson used smells they naturally associated with positive emotions that could 'momentarily' take them out of their thoughts and change their mood, "it takes me straight to when I was 8 years old, on the playground" (Lauren). This was also helpful for managing flashbacks, nightmares and dissociation, and Danny reported how it had helped him "get through the horrible bits" during trauma therapy.

Participants used inner dialogue as a resource when becoming overwhelmed, indicating less reliance on talking things through and having perhaps internalised the instruction and reassurance they previously got from the military and others who supported them,

> I will talk to myself. For motivation to just calm down. You know 'you're not in danger'…you don't talk to yourself but it's just inside your head and I find that having a monotone voice in my head, listening to that is helpful. It just calms me down and I can carry on (Craig).

In addition to methods of calming emotions in situ, most participants discussed importance of taking time out and gaining distance from some situations, e.g. interpersonal conflicts. This ranged from taking a moment outside, to spending extended periods of time in their car. For some the 'antisocial' nature of leaving without explanation caused conflict, but escape was considered the lesser of two evils, "It's a very selfish thing to do, very selfish, but you don't think straight. It is what I needed, I took myself out of the situation" (Stan). Danny and Jackson acknowledged that they aimed to cope with situations rather than escape, so planning was needed to make coping strategies accessible and discrete, so they could be used in public without drawing negative attention and feeling paranoid about how others perceived them.

In addition to developing clear, concrete strategies for managing PTS, participants reported developing an ability to see positives in their lives and the world around them which balanced their negative experiences. This generally involved being open to new, creative

approaches to expressing emotions which allowed different ways of viewing their difficulties to develop. Initially participants resisted this based on a lingering masculine military identity, but were able to overcome this with results that surprised them,

> I was never up for it, I was a combat veteran, not a bloody artist [laughs], but I was encouraged to go and art to me is, and I have been quoted for saying that it's better than any medication. In fact since I started doing it I've come off a lot of medication...I learned that the more I did it, the less mentally I was suffering (Danny).

Participants were willing to change this part of their military identity, as they recognised it had not served them well for managing PTS.

A factor in participants' openness to new methods of expressing emotions was encouragement from others that they respected. Stan explained how he had returned to the Falklands and discovered the national flower there whilst painting the landscape. He expressed the symbolic impact of this flower as an 'antidote' for him,

> I can still smell that horrible smell from 82 but it was a big antidote, shall we say, for it...And it had quite a big impact on me. I met a couple of guys, one of which had been a royal marine who was a musician, and he had written a song about his own experiences. And he was taken with the effect this flower had had on me and he said you need to write a song about it. And I laughed at him and said I haven't got a musical bone in my body. He said just do it, write it. So I did.

Other participants described integrating creative solutions into therapy, for instance Danny reported painting a dominant character to use in his mind when overwhelmed by thoughts and imagining dialogue with the subject of his nightmares, both of which he reported led to reduced symptoms. Jackson focused on things he liked to help him cope with things that made him anxious, for example focusing attention on the sound of jets prior to taking off helped him with fear of flying. Lauren found creative outlets through gardening and music, which she could match to her mood to make her feel calm and less isolated.

Most participants described reaching a point where they felt they "circled back around" (Terry) to regain an identity that reflected positive elements of their military career. This primarily involved engaging with veteran communities, in which two participants gained

employment and a further two voluntary roles. Involvement in these groups was associated with an enduring sense of belonging comparable to that experienced during participants' military days. Whether participants worked for the organisations or not, they found that being able to understand and support other veterans due to their experience rewarded them with a sense of usefulness. The identity participants settled upon was strengthened by acceptance within the veteran community,

> I'm getting to that point now. It seems to have gone in a massive circle….getting back within the community, helping with my mates here. I've got a new bunch of lads, and this place is a family, it is a family. Before I came here I hadn't laughed for months, and I have got this place 110% to thank for where I am now (Craig).

Participants found it "incredible" (Danny) and "a joy" (Jackson) to be able to pass on what they had learned about managing PTS through supporting others with similar difficulties, giving them a sense of purpose and pride that they found healing,

> Now guys come to me, because of what I've gone through, what I've done in the army, what I've gone through since, they always feel confident talking to someone who's in the same boat, somebody that's been there and done it perhaps. But for me that's therapeutic, for me (Danny).

Paid and voluntary work was further associated with self-worth as roles involved being trusted with responsibilities, making participants feel respected and valued.

A final element of renewing lost identity for three participants was re-engaging in activities they stopped when they were injured. Sports had previously been an important part of who they were and a resource for managing stress. Participants found that by adjusting their expectations and how they practised sport, they could find meaning in returning to an active, competitive environment.

Discussion

The findings of this study provide detailed understanding of what helped a small sample of veterans successfully manage PTS, as part of a wider journey of a difficult, unplanned transition from military to civilian life. Findings indicate that processes of

managing PTS and renegotiating identity were intertwined throughout this journey. Positive parts of identity participants felt they lost on leaving the military were rebuilt, and more problematic parts were challenged, in order to accept PTS as a problem, talk about it and manage it. Participants sought to speak about their difficulties with others who understood the military context and therefore did not judge them for what they had done or experienced. Judgement and incompatible values were a source of stress that made PTS harder to manage. In time, participants reported growth from their experiences which made them a valuable resource to others, adding to a positive sense of identity and value. Challenging traditionally masculine ways of expressing emotions opened up alternative way of viewing and managing emotions. This study most significantly advances knowledge in the field of PTS in veterans by outlining what is involved in the full journey of successfully managing PTS, which not only involved finding effective strategies to manage symptoms but also broader processes of identity renegotiation and navigating the social context in order to access the right help.

Findings support existing evidence that masculine socialization within the military is linked to difficulty recognising problems and seeking help in the veteran population (Lorber & Garcia, 2010). In the current study Lauren's views on the military way of coping were similar to those of male participants, fitting with evidence that females are also subject to military masculinity, in some ways at a higher level in order to compete with males in the same role (Demers, 2013). This socialisation and indoctrination into military processes helps to explain the veteran-civilian divide described in findings, as is found in the research elsewhere (Ahern et al., 2015). Gronke and Feaver (2001) commented on a "latent alienation and distrust, suggesting deeper ideological and attitudinal divides between the military and the public it serves" (p.132). Military masculinity and the veteran-civilian divide will be discussed further within the critical appraisal section of the thesis.

Participants' initial denial of their problems and avoidance of responsibility indicated an external locus of control, i.e. where events outside the self are seen to have control over a person's life (Rotter, 1990), which Smith et al. (2018) particularly link to avoidance elements of PTS. This is consistent with a cognitive-behavioural maintenance model of PTS, where unhelpful and inaccurate beliefs about the self, others and the world lead to ineffective coping behaviours such as avoidance which reinforce beliefs and prevent change (Ehlers & Clark, 2000). Participants' low points were depicted as points at which they started to challenge beliefs that they had no control over PTS and their lives, thus developing an internal locus of control and taking responsibility for learning more effective ways of coping. The idea of 'hitting rock bottom' is endorsed in literature on problematic alcohol use as a necessary part of recovery, where motivation to change is a function of fully realising the consequences of the problem and that it cannot continue (Kirouac, Frohe, & Witkiewitz, 2015). Although Kirouac et al. (2015) found individual variance in events which precipitated 'rock bottom' and how quickly it led to change. Current study findings seem most useful in terms of exploring whether early intervention can avoid veterans having to reach this low point before change seems available to them. Fostering an internal locus of control may help veterans take responsibility for learning how to manage PTS, rather than avoiding it and risking associated negative outcomes. Participant's comments about having an internalised voice of reassurance and support that helped them fits with the idea of developing an internal responsibility for managing emotions. Furthermore, research has connected an internal locus of control with reduced PTS symptoms over time (Karstoft, Armour, Elklit, & Solomon, 2015).

The second theme highlighted the importance of consistent long-term support which allows trust to be built and complexity to be accommodated. Participants found some civilians too direct and insensitive, leading them to feel excluded from civilian mental health services and their wider community. This seemed to add to veterans views that they could not

relate to or identify as civilian. Binks and Cambridge (2018) reported that being unable to relate to civilians caused identity conflict for veterans during the transition that took years to resolve, particularly for those who were engrossed in a military identity. Sayer et al.'s (2009) findings support that veterans consider invalidating socio-cultural environments following traumatic experiences a barrier to talking about their experiences. The current study findings add that veterans appreciate an indirect communication style initially, allowing them to open up at their own pace, and access to specific advice and direction once the problem has been established, in order to help them to 'combat' symptoms.

Validating societal responses to self-disclosure of experiences and emotions may be an important factor in post-traumatic growth (PTG; Calhoun, Cann, & Tedeschi, 2010). Current findings support this, as validating responses within the veteran community contributed to participant's growth as a result of their difficulties, which they then shared with others to develop a positive identity around purpose, worth and belonging. Morris, Campbell, Dwyer, Dunn and Chambers (2011) similarly found that peer support provided a source of positive role models, helping to affirm a "strong survivor identity" (p.660). PTG in the current study seemed to result from low points participants experienced, which brought on a significant change in how they approached problems and emotions. These findings support Palmer et al. (2017), who conceptualised the low point as a 'catalysing crisis' that instigated PTG. For participants of this study it was also important to take responsibility for managing symptoms and emotions through having clear, pre-planned strategies they could access on a daily basis. This fits with findings of Maung, Nilsson, Berkel and Kelly (2017) that using routine activities is a valuable resources when reintegrating into civilian life. So whereas PTG and identity related to a broader sense of meaning and growth as a result of PTS, gaining control of PTS involved actively combatting symptoms by making use of

concrete strategies. Both were highlighted as required for participants in this study to manage PTS effectively.

Clinical Implications

Current service provision for veterans in the UK includes priority access to civilian services for military-related difficulties, national veteran-specific mental health services provision across England (National Health Service (NHS), 2018), and/or referral to community veteran's organisations or charities, some of whom provide therapeutic input and informal support.

Due to the value of peer support in all stages of managing PTS, it would be beneficial for GPs and mental health services to identify veterans experiencing problems as early as possible and to offer them the option of community veteran organisation input. This was a vital resource for participants of the study, however they all found out about these organisations after input with a military-specific service, which was after they had reached a low point. These resources could be better accessed earlier on in a veteran's journey of managing PTS if referral sources were wider. This could be achieved by providing education to GPs and primary and secondary mental health teams on the importance of identifying previous military service, signs that veterans may be struggling and increasing awareness of organisations that could help them. Better links between NHS services and community organisations could be formed through direct contact, and it would be helpful if details of such organisations were included on the NHS veterans' mental health webpage.

Considering the substantial comfort and validation participants felt being around other veterans, group interventions seem an effective way to engage veterans, particularly in the early stages of input within generic and military-specific services. Current findings suggest this setting may be a catalyst for veterans to start talking about their problems. A group setting is also suitable for providing psychoeducation on beneficial coping strategies and

techniques to help veterans replace ineffective coping methods with ones that are harmless and effective. Informative therapeutic groups have previously been demonstrated to reduce symptoms of PTSD (King et al., 2013; Swanson, Favorite, Horin, & Arnedt, 2009), which is promising. Holding groups in informal settings, perhaps run by veterans trained for this purpose, is likely to help veterans feel more comfortable to open up. Furthermore, there is evidence that motivational enhancement therapy can be effective for challenging traditionally masculine responses to emotions (Lorber & Garcia, 2010), so using this approach in a group setting may allow veterans to identify problematic aspects of their identity that are making PTS more difficult to deal with and move towards gaining an internal locus of control in regards to managing PTS.

Participants in this study valued having a set plan for managing their symptoms. For veterans newly discharged, or not wishing or ready to access mental health services, a central resource on strategies to manage PTS created by veterans would likely be beneficial. This would allow wide dissemination of many valuable resources for keeping calm, and a briefing on returning to civilian life containing things veterans wished they had previously known.

Research Implications

It would be useful to pilot and evaluate effectiveness of veteran peer support groups as an early intervention for veterans identified as having difficulties with PTS. This could take place in an NHS or community organisation setting. Motivational enhancement therapy groups could also be trialled within NHS services for veterans not ready to engage in talking therapy. It would be useful to gain both quantitative data on effectiveness and qualitative data on the experience and meaning gained.

Further qualitative research may also aim to understand the impact of failed social acceptance by civilians and civilian systems on veterans' ability to manage PTS, and what they feel would be important for bridging the cultural gap. Current study findings indicate

that mixed veteran-civilian groups led to veterans seeing civilians more favourably. It would be interesting to see if this applies more broadly, as this could provide rationale for a higher level of civilian community engagement by veterans' organisations.

Strengths and Limitations

For this IPA study the researcher initially aimed recruit between six and twelve participants. Once the first six interviews were completed and transcribed the richness of the data was assessed as high, since participants had taken time to talk about their experiences in detail. This was a key strength of the research. The sample was judged to be homogenous in participants' experience of PTS, such that it was clear the themes emerging from the data were going to be broadly similar. Recruitment was therefore stopped at six. The sample included one female veteran and two were from a minority ethnic group. It is positive that the small sample represented some diversity, however considering the thread of challenging aspects of military masculinity and renegotiating this identity, more female views on this aspect may have further strengthened findings, or presented an alternate viewpoint.

Whilst conducting this study the researcher was working within veteran-specific mental health service, which may have introduced an element of bias. This will be discussed further in the critical appraisal section.

Conclusion

Successful management of PTS for veterans in this study was intertwined with renegotiating identity as a veteran, incorporating positive elements of who participants were with who they had become through learning to manage their difficulties. Participants challenged problematic elements of their identity to gain control of PTS, and open themselves up to new ways of seeing emotions and coping. Talking to other veterans and professionals with understanding of military context helped participants gain validation through social acceptance. Being part of a veteran community, with experience that could help other

veterans was considered therapeutic and further strengthened positive parts of a renegotiated identity.

Important implications arising from these findings are to pilot and evaluate effectiveness of veteran peer groups, to form resources veterans can access on discharge to make transitioning to civilian life with PTS easier and to make community resources more visible to veterans. Raising awareness of community resources for veterans amongst GPs and other civilian professionals is needed.

Table 1: Participant demographic, military and clinical details

Participant	Age	Military branch	Role	Years served	Employed	Diagnosis/ Diagnoses	Symptoms reported
Danny	58	Army	Gunner	1976-1983 (8 years)	Volunteer	PTSD, dissociative disorder, personality disorder	Hypervigilance, avoidance of reminders, nightmares flashbacks, dissociative episodes, audio hallucinations
Stan	58	Navy	Catering accountant	1976-1983 (8 years)	Part-time	Adjustment disorder	Flashbacks (triggered by smell), avoidance, anxiety, anger, alcohol misuse
Terry	63	Army	Sergeant	1972-1987 (15 years)	Not employed	PTSD	Anxiety, flashbacks, hypervigilance, anger
Lauren	56	Navy	Medic	1986-2000 (14 years)	Part-time - Permitted work scheme	PTSD	Flashbacks, disturbed sleep, anxiety, anger, hypervigilance
Craig	44	Army	Engineer	1990-2000 (10 years)	Part-time	PTSD	Nightmares, flashbacks, intrusive memories, anger, panic, social anxiety, avoidance, hypervigilance
Jackson	33	Army	Medic	2005-2010 (5 years)	Volunteer	PTSD	Hypervigilance, nightmares dissociation, anger, flashbacks, avoiding situations

Note: Pseudonyms given to protect anonymity

Table 2: Examples of exploratory comments and emergent themes from an extract of Danny's transcript

Emergent themes	Transcript	Exploratory comments
Making sense of symptoms. Long haul support – one thing at a time. Become a statistic or combat problem.	R: Can I ask about your experience with PTS? P: Its symptoms of many things that I was having. I was very reactive to noise, I was very erm, my observation was still very, very observant to my surroundings. I'd never go down the same, say if I was going on the school run or something like that, I'd never go the same way twice, I'd always change it. And all these things started to make sense, nightmares, the flashbacks, the erm what they diagnosed, it was called dissociative disorder, but I also had a personality disorder. So once I started to learn all about that, you know, you could work with one thing at a time, and while I was at combat stress I had the opportunity to, I didn't want to live the life I was living so it was either learn and help combat what was going on…. I mean, I was in the Falklands. I was in a team of 12 OPs and there were 6 teams of 2, and we had an incident one night where we were out on the field, me and my mate spotted this guy and we had to go forward to reckoning position and there was a huge blood trail. I took the shots, and there was an Argentinian lying dead on the floor, and he was only about 15/16, but at night you couldn't tell that through a night scope. They were the enemy, they were well within our perimeter, they were a danger so they had to be taken out. And my mate dropped his	'Many things' to make sense of for participant. 'Things' distinct from one another. Emphasis on sensory symptom intensity Efforts to avoid taking the same route twice – absolute rule – 'never' 'always' Making sense of symptoms through connecting them to PTS Labels for difficulties gave focus to start learning. Labels seem useful? Different things, but related Learning means you can work on one thing at a time Combat stress gave opportunity to work at his pace Life reached point where change must happen – either learn and combat it… Tailed off sentence to talk about 'incident' in Falklands – wanting to illustrate a point through telling this story 'huge blood trail' 'I took the shots' - illustrating gravity of situation and his part in it Conveys sense of conflict about unknowingly having shot an adolescent male Doing the job he had been asked to do – as part of military role. Clear on mission despite moral conflict

Taking responsibility. Hard but necessary decisions. Accepting PTS. Taking responsibility.	weapon and said, 'I'm not doing this anymore, I just can't do it'. And he was dishonourably discharged and things like that, and he became very unwell, and out of the 12 of us, all of us came back with minor injuries, but fine still able to soldier on, until my leg when gangrenous, and then I had no choice then. I almost lost my leg through gangrene. A couple of days later on and I would have lost it. But out of the 12 of us, 10 have died by their own hands. I was having funeral after funeral after funeral, and seeing the devastation it does to the family as well, and I'd already put my family through a lot, which was why I left home, because it got to the point where I couldn't put my family through anything else. It was telling on them, they started to have symptoms of mental health because of what I'd put them through. So I just left. Packed a bag and left home, and it turns out it was probably one of the best things I ever did. The hardest thing I ever did. But while I was at combat stress I started to learn all these different things and I thought 'it's gotta stop'. So I went to all the different groups, learned as much as I could about what was going on, tried to have an understanding. And I stopped saying why me, and more like, well for whatever reason I'm going through this, I need to do something about it.	Mate reached breaking point – unable to continue Dishonourably discharged and became unwell – relevance of opting to leave? Shame implied in 'dishonourable' Resilient to minor injuries 'soldier on' 'no choice' – his choice would have been to 'soldier on' if he could? Extreme consequences mitigate potential guilt about leaving? 10/12 'died by their own hands' – suggests unable to cope with what they had to do as part of role Frequent funerals of friends and colleagues Suicide devastates family Already put family through too much to put them through what he witnessed at others funerals Left to avoid further pain for family – took responsibility for families welfare Recognised impact of past behaviour on family – 'symptoms of mental health' – felt he had caused others mental health to decline 'best' 'hardest' – difficult to do in short term but turned out to be best plan long term Learning about problems associated to motivation to change 'its gotta stop' Becoming informed to explain experiences 'why me' – implies victim mentality - changed when he became informed Deciding to take charge, take responsibility

Table 3: Participant emergent themes related to superordinate themes

Participant	Danny	Stan	Terry	Lauren	Craig	Jackson
Theme 1: Accepting the problem, taking responsibility and gaining control	Army way – hide emotions. Lost in civvy street. Became ill fast – slow to realise. Moved focus away from self. Complex problems deepen with denial. Not taking responsibility. Life in hands of fate / others. Actions can no longer be denied. Hard but necessary decisions. Become a statistic or combat the problem. Taking responsibility. Accepting PTSD – no more excuses. Making sense of symptoms. One thing at a time. Gaining control mitigates shame. Challenge PTSD as a weakness. Finding courage.	Stuck in military mindset. Left alone - no forward brief, no resettlement. Stuck in a cycle. Life in hands of others. Low point. Lightbulb moment. Others have their own rules. Actions have consequences. Motivation to change. Still stuck in cycle.	Army rules – shut up about emotions. Military tie cut – left useless. No resettlement. Chip on shoulder. Explode at the smallest thing. Life in hands of fate. Came to a crescendo. Considering the consequences. Replugging your own wires. Feeling in control. Using courage to access help.	Grit teeth and get on with it. Not desensitised or prepared for civvy street. Didn't see it starting. Rock bottom - considered suicide. Resolve to find another way. Manage it as best I can. Fate in the hands of others.	Army way – suck it up soldier. Train you up and let you go. On your own in civvy street – thanks, bye. Is this it now? Being an idiot but couldn't see it. Mental breakdown – saved from suicide. Changing point. What am I doing? Others as inspiration and clarity. Others inspire courage. Coming out the other end. Challenge PTSD as a weakness.	Army way – soldier on. Mind in Iraq – body in UK. Loss of physical functioning. Abnormal became normal. Breakdown of family – feeling suicidal. Motivation to change. Problem can be treated not cured. What have I been doing?

Participant	Danny	Stan	Terry	Lauren	Craig	Jackson
Theme 2: Talking to the right people	Painful but necessary. Long haul support – one thing at a time. Not under the spotlight. Other veterans in same boat. Tell me what to do and I'll do it. Civilians don't have the understanding.	Calmed through relating. Veterans no pressure. Government on different page. Civilians a risk not a help. Face to face support.	Talking to the right people. Unbottle it. Indirect more comfortable. Veterans have unwritten rules – know without knowing. Veterans no pressure. Civilians judge a book by its cover. Served country but not served me. Tell me what to do next time.	Too complex for treatment. Doctors don't care. Services inflexible. Veterans get it. Comradery and banter. I'm not a civvy – can't go backwards.	Talking releases emotion. Once open can't close it. Understand / accept military context. Trauma upsets civvies. Calm/unrushed vs interfered with. Support that won't leave. Veterans – no questions and answers. I'll do what I'm told.	If other veterans can talk I can. Patience, trust and understanding. Accept you as you come today. Adjustments make big difference. Mistrust civilian services.

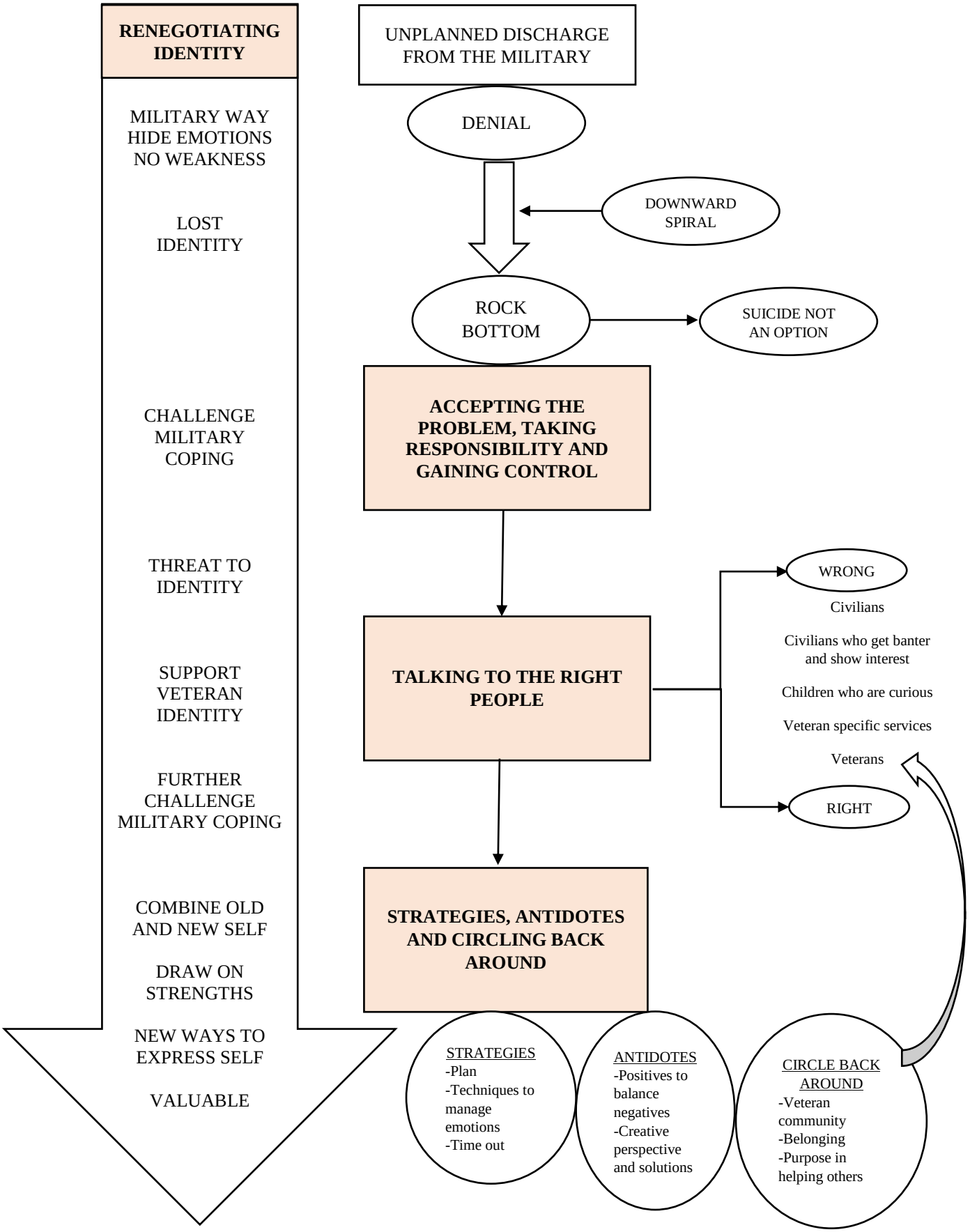
Participant	Danny	Stan	Terry	Lauren	Craig	Jackson
Theme 3: Strategies, antidotes and circling back around	Time out - selfish but necessary. My time. Small things together have a big impact. Smells to ground. Discretion avoids attention. Self-talk – gain control. Expressing emotions releases them – it's not weak, it's needed. Open to creative outlets. Moving past resistance. Symptoms there but not as bad. I can teach others – useful again. Responsibility conveys respect. Accepted and valued. Permanent belonging. Helping others helps me.	Escape pressure and burden. Escape avoids consequences. Putting in the hard work. Detail the plan. Antidote – symbol of what's good. New ways to express emotions. Soldier not an artist. Open your eyes, see beauty in the world. My experience can help others. Job satisfaction.	An antisocial illness. Drawing on past skills. Having a plan in place. Organise yourself the military way. Use the good to balance the bad.	Managing is keeping calm. Escape to avoid response. Elvis knows how I feel. Grounding – from anger to childhood memories. Keep busy but pause to be present. Military structure. Self-talk – keep calm and release anger. Positives balance negatives. Adjusted expectations. Gaining sense of self back – sport and veterans.	Take a break – calm down. Strategies to match symptoms – a clear plan. Grounding and distracting – get out of thoughts. Monotone voice in head. Fingers are black not green. Finding positives in life. Symptoms unpredictable but less frequent. Circle back to past identity. Back to competition. New parts of identity valuable.	Process not a one day fix. Hard work. Taught like a baby to speak again. Take a break, change the response. Discretion avoids paranoia. Momentary mood change. If it works double it. Symbols of calm. Shift the burden of worries. Self-talk reassuring. Positives to balance negatives. Symptoms short lived. Joy derived helping others.

Table 4: Narrative summary of contribution to superordinate themes for Danny

Theme 1: Accepting the problem, taking responsibility and gaining control
Danny explained that the army way of dealing with emotions was to hide them, which led to an avoidant style of coping that became problematic for him because he was not able to see, or was denying that he 'became ill really fast'. He talked about having a difficult transition brought about by his wife's ultimatum to leave or she would leave him. He didn't feel in control of himself and what was happening in his life, and reflected that he was not taking responsibility for his actions or for using coping strategies that made him worse. It was scary and frustrating for him that he couldn't understand what was happening with his emotions, experience and behaviour. This culminated in him nearly harming his daughter during a dissociative episode, which triggered him to leave home and stay in his car to get some time alone. He felt this was the hardest but the best decision he had made, as having some space from his family allowed him to focus on what was happening for him. It 'made me realise that I needed to do something about it, or I'm just going to be another statistic'. This was something he felt he couldn't do to his family after attending many funerals and seeing the impact it left. Giving in to it all wasn't an option. A friend helped him arrange contact with a veteran-specific organisation at this point and for him, learning about PTS and other symptoms he was having allowed him to start understanding what was going on. He talked explicitly about taking responsibility and a change in his approach – instead of why me, it was facing the problem and learning how to combat it that he wanted to start putting his energy towards. This allowed him to start gaining a sense of control over managing PTS.
Theme 2: Talking to the right people
For Danny opening up was seen as a key part of managing PTS. He described changing from someone who avoided talking about emotions to being able to talk freely about them. He emphasised that this related to having the right people to talk to at the right points in his life. He was given strong direction from friends and services he subsequently entered which he found helpful, as he still had reservations about talking to mental health services – related to views that civilian professions would not understand his difficulties. Once he started learning what was going on for him emotionally he was given time to look at one symptom at a time. The consistency of the treatment he was offered was considered essential, as he was experiencing many symptoms at the time. He described finding it difficult at first to speak about his issues, especially in individual trauma therapy. Meeting other veterans with similar problems was a big help to him, as they described being in the 'same boat' as him. This gave him confidence to start speaking about his difficulties. He found that he was most able to open up in an informal environment with other veterans where there was less of a spotlight on him to provide answers to therapist's questions, and emotions could be diffused through banter. He felt that civilians could be insensitive of the military context, and that it would work better if all healthcare professionals showed an interest in whether their patients were ex-military. Danny had some positive experiences of mixing with civilians in his community, finding that they were able to get the military humour, and also that he found it easier to share his experiences of war with children, as when they asked questions it was done with interest and innocence.

Theme 3: Strategies, antidotes and circling back around
Danny indicated that there is no one strategy for managing PTS, but that putting together all the small things he had learned led to a big impact on the control he had over his emotions. The small things included ‘simple things’ like using smells for grounding when lost in thought or emotion, having a schedule to structure time, talking to himself to create a calm headspace, using discrete methods of grounding in public and taking time out at times if completely overwhelmed. Danny stayed in his car when he initially left home and he reported escaping at other points also, the purpose was to have his own time where he could focus on his needs. He felt this was selfish due to the impact it might have on others that he would leave them, but he reflected that those decisions had allowed him to get a better outcome in the end. Danny became more open to trying methods that he initially saw as ‘daft’ or not in line with his identity as a combat soldier, with others in the groups he attended (e.g. art group) encouraging him to just have a go. Through doing this he emphasised the value of expressing his emotions in this way as an outlet, and reported finding surprising positives through creative exploration that then became symbols of his recovery that meant a lot to him (e.g. he painted a silverback gorilla which he used to create a dominant calming voice in his head which helped quiet his thoughts). Danny had started volunteering for a veteran community organisation after attending there as a service user, and found that having the chance to belong to a veteran community again, as well as being able to teach veterans what he had learned about art and coping strategies gave him a new sense of identity that gave him some of his old military self back and also allowed him to integrate what he had gained through his experiences with PTS. He found therapeutic value in helping others, and found the respect and responsibilities invested in him validating for his self-worth and feeling useful again.

Figure 1: Visual representation of themes and key emerging concepts for successfully managing Post-Traumatic Stress



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Ordinarily, manuscripts should not exceed 26 pages and 8,000 words, including tables, figures, and references. Manuscripts received which are significantly higher than the limit will be automatically rejected. Manuscripts are subjected to blind peer review and thus it should be anonymized. The author's names and self-citations should be removed or blacked out. Any other identification, including any references in the manuscript, the notes, the title, and reference sections should be removed from the paper and listed on separate pages, e.g., title page.

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Conference Paper
Williams, J., & Seary, K. (2010). Bridging the divide: Scaffolding the learning experiences of the mature age student. In J. Terrell (Ed.), *Making the links: Learning, teaching and high quality student outcomes*. Proceedings of the 9th Conference of the New Zealand Association of Bridging Educators (pp. 104-116). Wellington, New Zealand.

Podcast (audio or video)
Rozaieski, B. (2011). Logan cabinet shoppe: *Episode 37: Entertainment center molding* [Video podcast]. Retrieved from http://blip.tv/xxx

Thesis (online)
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Books

Book with place of publication
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Book with editors & edition
Collins, C., & Jackson, S. (Eds.). (2007). *Sport in Aotearoa/New Zealand society* (2nd ed.). South Melbourne, Australia: Thomson.

Book with author & publisher are the same
MidCentral District Health Board. (2008). *District annual plan 2008/09*. Palmerston North, New Zealand: Author.

Chapter in an edited book
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Section Three: Critical Appraisal

Critical Appraisal

This thesis includes a systematic literature review of female veterans' experiences of reintegration into civilian life and a qualitative empirical study of what helps veterans successfully manage Post-Traumatic Stress (PTS). Although the two papers address different research questions, there was overlap in the broader concepts expressed in their findings. Mental health and emotional difficulties impacted on reintegration, and problems reintegrating impacted on mental health. When participants arrived home they did not feel like the same people they had been when they left. Reintegrating required participants to negotiate the loss of military identity and transition to being a veteran-civilian. Two problematic areas identified within this identity renegotiation were beliefs that framed emotional difficulties as a personal weakness and being unable to relate to civilians due to perceiving them to lack understanding of veterans' experiences. This led participants to cope through avoidant means rather than gaining access to help and support, which for some participants culminated in reaching a low point where they had considered suicide. This critical appraisal will reflect further on the military-veteran identity and the veteran-civilian divide as broad problematic concepts for veterans emerging from both sets of findings. Future directions for research and intervention in these areas will be suggested. Finally, reflections will be offered on my position as a civilian researcher working within a military veteran service as a trainee clinical psychologist when the research was conducted.

The Military-Veteran Identity

In the findings of both articles participants discussed the problem of identity reconstruction following discharge from the military. The problem was twofold; on one hand military identity was lost, in terms of role, rank, status and belonging to the military, and on the other hand elements of the military identity remained ingrained, which became problematic for managing emotions and mental health during the transition. This supports

Morin's (2011) findings that problems such as PTS on discharge make reintegration more difficult.

Stigma around talking about and seeking help with emotions and mental health difficulties is not exclusive to veterans, indeed it has been widely discussed and researched within mental health literature generally. For instance a systematic review of quantitative and qualitative research by Clement et al. (2015) identified a small to medium effect size for stigma as a barrier to help seeking in the general population. However, they identified that certain groups are "disproportionately deterred by stigma" (Clement et al., 2015, p.11), which included men and military personnel. These groups cross over, as the majority of military personnel are male, at least within the Western military (Schjølset, 2013). Being deterred from seeking help due to stigma is supported by findings within the themes 'accepting the problem, taking responsibility and gaining control' from the empirical study and 'the immediate emotional aftermath' from the literature review. Within these themes participants explicitly related not seeking help for emotional difficulties to beliefs they formed during their military career that framed problems with emotions as a personal weakness. In the empirical study, participants initially reported denying their emotional difficulties even to themselves.

Participants' reported beliefs fitted with the idea that military socialisation involves construction of a traditionally masculine soldier identity, which idealises toughness, aggression and endurance (Hockey, 2003). This masculine identity replaces individual identities systematically during basic training, with the aim of creating a socially cohesive group capable of operational effectiveness (Harrison, 2003). This process turns recruits into disciplined soldiers, who are ultimately willing to sacrifice themselves for their mission and colleagues (Braswell & Kushner, 2012). The transformation from civilian to soldier has been spoken about interchangeably with the transition from 'boy to man' (Herbert, 1998).

Suppressing emotions to remain physically and mentally capable in situations of high stress and danger is rewarded informally through social capital, e.g. peer respect and admiration, and formally through decoration for bravery and merit (Braswell & Kushner, 2012). The masculine identity described is in line with the hyper-masculinised norms of 'hegemonic masculinity', where displaying masculine traits legitimises one to have power and dominance over others who are considered weaker and more feminine (Connell, 2005). Physical and mental performance is framed as feminine if military personnel are not able to meet the standards of their peers. Whitworth (2008) highlighted how this can be problematic for those who develop mental health difficulties through military service and trauma exposure, as speaking about these difficulties could lead to loss of masculine status and identity. This may help explain some of the extra stigma experienced by military personnel outlined by Clement et al. (2015).

Participants of the empirical study and review found that managing emotions in traditionally masculine ways became increasingly problematic for them as it did not help them deal with the memories, trauma, loss and bottled up emotions they brought home with them. In the review, compartmentalising emotions was considered only temporarily effective, as it was linked to periods of unpredictable outbursts of emotion and feeling disconnected within close relationships. The empirical study linked denying emotions and PTS with a downward spiral of avoidant coping that resulted in hitting 'rock bottom' and considering suicide. Braswell and Kushner (2012) argued that military masculinity is explicitly linked to higher rates of suicide in military personnel and veterans. Rising suicide rates in military personnel and veterans have also been linked to other factors, such as depression, PTS and problematic alcohol use (Pietrzak et al., 2010a), but the current findings add weight to the argument that being unable to acknowledge and seek help for emotional

difficulties not only impedes reintegration and managing PTS, but it also can have severe consequences.

Ideals of masculine identity endorsed by the military may have further consequences for those who experience Military Sexual Trauma (MST), sexual harassment or gender-based derogatory treatment, as it creates a culture where bullying is reframed as "laddish banter" (Green, Emslie, O'Neill, Hunt, & Walker, 2010, p.1483). Indeed Sasson-Levy (2003) reported that females within the military tended to trivialise gender-based treatment as being part of their everyday culture. This makes it less likely that personnel will report such incidents or seek support in relation to them, as it reduces confidence that they will be taken seriously. This was reinforced by the findings of the literature review, where some women described becoming more masculine to cope with feeling like an outsider due to their gender.

Stigma associated to identifying with a masculine military identity has been well documented in the literature previously (Lorber & Garcia, 2010). In interviews with military personnel, reasons for not wanting to seek help commonly included fears they would be seen as personally weak, would be treated differently by unit leadership, that colleagues would have less confidence in them and that it would harm their career (Hoge et al., 2004; Kim, Thomas, Wilk, Castro & Hoge, 2010; Iversen et al., 2011). Similar beliefs have been found across Western military nations (Gould et al., 2010). In terms of how this impacts on help seeking, Iversen et al. (2010) reported that only 23% of United Kingdom (UK) serving personnel who reported mental health difficulties were seeking support from services.

The Ministry of Defence (MoD) have recognised that stigma is a factor in recognising and getting help for mental health problems within the military, and have allocated funding for interventions that aim to address this (MoD, 2018a). This included the anti-stigma campaign 'Don't bottle it up' in 2011-2012, that focused on normalising combat

stress and common mental health problems to encourage personnel to talk about them. Military personnel and their families have also been offered briefings on identifying mental health problems pre- and post-deployment. This is positive considering that findings of the review and study indicated that some veterans needed prompting to seek help, even when they had reached rock bottom. The MoD have also collaborated with mental health charity Samaritans to produce a suicide prevention and peer support pocket guide for military personnel (MoD, 2018b), and with Combat Stress to set up a military mental health helpline from February 2018 as a source of confidential support and advice for military personnel and veterans.

It is positive to hear that these strategies have been implemented as avenues of support for military personnel and veterans. However, for an anti-stigma campaign to work effectively, the stigmatised population would surely need to have faith that disclosing problematic emotions or mental health problems would not lead to negative consequences. Unfortunately, it is possible that disclosing problems within the military chain of command may impact on an individual's career, suggesting that fears outlined by Kim et al. (2011) and Iversen et al. (2011) are well-founded. The MoD state that where fitness to practise "falls below the Service employment and retention standards the board will recommend a medical discharge" (MoD, 2017a, p.2). They outline that efforts are being made to retain staff who incur physical or mental injury, so personnel may be temporarily or permanently "downgraded" to a role they are capable of fulfilling, as opposed to being discharged. In 2016-17, 22% of UK army medical discharges were due to 'mental or behavioural disorders', which was the second most common reason for discharge after muscular skeletal problems (MoD, 2017a). It is likely that fear of being downgraded or discharged, and the subsequent loss of role and status, may act as a deterrent against seeking help for mental

health and undermine strategies funded to improve the mental wellbeing of personnel. The message, although less explicit, is still that it is not ok to not be ok.

In findings of the current empirical study an informal peer environment was the place veterans felt most comfortable opening up about their difficulties, as in this setting the problems they experienced were normalised by others whose experiences were similar. They were also more likely to consider trying less traditionally masculine forms of emotional expression if other veterans were doing it and if it was encouraged by those they respected. Emslie, Ridge, Ziebland and Hunt (2006) found that positive masculine identities can be formed outside of hyper-masculinity, since addressing emotions and talking about problems is difficult to do, so doing it can thus be considered a display of strength. In the empirical study participants changed their views on talking about their difficulties in line with this, seeing talking as difficult but necessary. Most importantly talking had an important role in managing PTS, as it allowed access to social support. The importance of social support for managing mental health has been highlighted in the literature elsewhere (Ozbay et al., 2007; Pietrzak et al., 2010b). From this information it seems reasonable to conclude that establishing more robust routes for peer support within the military is likely to be helpful. It would be less stigmatising for individuals if they were able to access support outside of their unit and chain of command, so that fear of being seen or treated differently by colleagues does not act as a barrier. A peer support service co-ordinated by veterans may be advantageous, due to their experiences in challenging aspects of military masculinity and in managing their emotions and mental health. Within the theme ‘strategies, antidotes and circling back around’ veterans described helping others as therapeutic and that it gave them a positive sense of identity and belonging. It is therefore likely that such a service would be mutually beneficial.

Both the review and study outlined that participants did not address emotional and mental health problems until they were discharged from the military. Therefore better links between the military and veterans' community organisations would be beneficial so that veterans can make use of informal peer support from the point of discharge. Having input with other veterans during the transition period may allow newly discharged personnel to appreciate the importance of talking about emotions and getting the right help, in order to avoid developing bigger problems. Peer support and belonging to a community that understands veterans' experiences from an early stage may mean that fewer veterans end up at 'rock bottom' before accepting help and considering alternate ways of managing emotions.

It is important to address conflict between methods used to train military personnel to be effective in their role and the potential consequences of this training for subsequent emotional wellbeing, which stretch far beyond the end of military service. Military masculinity is deep-rooted within the military as an institution, and within the individuals it trains, making it an issue that is unlikely to be easily resolved or straightforward to address. However it is one which requires further thought, research and intervention. Braswell and Kushner (2010) warn of the violent emotional outbursts that result from suppression of emotions and strongly recommend that social cohesion required by the military be "encouraged in other, less risky ways" (p.6). Further research is needed in order to understand what an alternate training method that does not endorse gender-based socialisation would look like.

The Veteran-Civilian Divide

The issue of the veteran-civilian divide has come from the theme 'talking to the right people' in the empirical study and themes 'an outsider again in one's own home' and 'civvies and civvy systems' from the literature review. Within these themes, participants

described that due to their military training and what they had experienced whilst in role, they saw themselves as being fundamentally different to civilians. In some cases the perceived difference led participants to feel they could not relate to civilians, as civilians were not seen to understand or appreciate what they had been through. This is problematic because during this time veterans are renegotiating an identity for themselves as a veteran-civilian, so being unable to relate to civilians is likely to disrupt this process and heighten the divide between the two groups.

The divide between military and civilian populations is described in the literature as the civil-military gap, which Rahbek-Clemmensen et al. (2012) conceptualised as having four overlapping elements. They commented on differences in culture, demonstrated through attitudes and values, in demographics of the two populations, in policy preferences on public issues and in views on relationships between institutions such as the military and civilian systems and media. Differences in attitudes and values seemed to be the most problematic element for participants of the review and study, where civilians were described as focusing on trivial details, having inferior thinking and public systems, and failing to acknowledge and sensitively respond to what they had endured and experienced during service. This resulted in veterans feeling alienated and misunderstood, which led them to withdraw from others. Demers (2011) also found that veterans see themselves as different, and in many ways superior to civilians. She commented that the tension caused by feeling misunderstood and disrespected was a barrier to making connections with civilians that prevented veterans from fully integrating into civilian life. Elnitsky, Fisher and Blevins (2017) reviewed literature on reintegration and concluded that interpersonal, community and social aspects constitute three out of four key domains. It is therefore essential to further understand how this issue might be overcome.

Findings of the empirical study within the theme ‘talking to the right people’ helpfully distinguished between civilians participants could and could not relate to. Relatability determined how helpful veterans found the contact in managing PTS. Participants could relate to civilians within healthcare services when they were patient, calm, straight-talking, committed to helping them and had a perceived interest in and understanding of military culture. The preference shown for talking about problems with veterans and veteran-specific mental health services further emphasised the importance of understanding the military context. Raising awareness of veterans’ unique experiences and problems in civilian populations is therefore likely to be helpful. Lafferty, Aldford, Davis and O’Connor (2008) reported practical ways employers and educators can help veterans reintegrate, based on veterans’ experiences. They highlighted that it is helpful to show an appreciation of and interest in military service, keeping questions open to allow veterans to lead discussions around what they are comfortable with disclosing. Information such as this needs to be disseminated on a wider level than the published academic literature, such as by circulating an accessible summary within government run services like education and health.

Interestingly 82% of civilians interviewed within a MoD public opinion survey agreed that “people who have left the armed forces make a valuable contribution to society” (MoD, 2017b, p.7). However veterans’ views of civilians within the review and empirical study did not fit with this display of positive support, perhaps suggesting the situation is more complex than is evident from the survey results. Sparrow and Inbody (2005) argued that since World War 2 the civilian public have become less familiar with what the military actually do, as the conflicts they are involved in have become more remote. So support shown may be superficial, with a deeper understanding of their experiences of active conflict being lacking. Two veterans within the empirical study reported being able to bridge the gap between veterans and civilians through community engagement projects. A campaign to link

the two groups is well overdue, and this would seem to sit well within veterans' organisations as a community engagement venture. Veterans' organisations or charities would also be a useful source for providing the public with information that helps them understand veterans. Video campaigns have been used previously as a powerful means to convey veterans' difficulties, for example the 'Liberating lives' video made by Combat Stress (2018). It may be useful to record a video of veterans' tips for interacting with and supporting them, as this could then be posted online and widely disseminated through the community informally through social media.

Civilian Researcher Working in a Military Veteran Service

When I started this research project my identity was civilian researcher. I had an interest in complex trauma and how military service affects post-military life, but I was investigating the experiences of a group that I am not personally part of. Researching into unfamiliar groups has both advantages and disadvantages, for instance the unfamiliarity can allow a fresh perspective that might lead to new innovations. However it could alternatively be a barrier to picking up on more subtle expression of themes that would be obvious to an 'insider' who speaks the language (Berger, 2015). By the time I conducted the interviews I was working in a military veteran service as my third year placement in the role of trainee clinical psychologist. To participants, I was a civilian researcher showing interest in understanding their experiences, which may have made me appear more relatable. To me, I still no longer identified with the population I was studying, but I had become more familiar with the language they use and difficulties they commonly faced. This may have influenced my interpretations in positive and negative ways. For instance, I may have been more likely to pick up on subtle themes as suggested by Berger (2015). But I also may have interpreted what participants said within the context of knowledge and assumptions formed outside of the research process. The problem is that it is difficult to determine how much knowledge

and assumptions formed outside of the data impact on the analysis, or to separate one from the other in your mind.

In the literature on qualitative methods it is acknowledged that researchers are "intimately involved" in the process and product of research (Dowling, 2006, p.8), which has made objectivity an issue of interest and discussion within the field. The aim of qualitative research is not necessarily to be 'objective' but to be self-aware, critical and transparent throughout the research process regarding where impressions and interpretations have come from. Researchers have thus encouraged reflexivity in qualitative research, which is broadly defined as acknowledging, exploring and understanding "how social background, location and assumptions affect their research practice" (Palaganas, Sanchez, Molintas, Visitacion, & Caricativo, 2017, p.17). There were two main ways that I practised reflexivity throughout data collection and analysis; by keeping a reflective journal so I could be aware of my own thoughts, beliefs and assumptions that emerged throughout the process (Ortlipp, 2008), and making use of regular research supervision to discuss my reflections, and key ideas and concepts emerging from the data.

I used my reflective journal after each interview to record initial impressions of what participants said and how I felt we had related. To give an illustration of the reflexive process, one factor that was notable to me was that participants provided a lot of contextual detail around the traumatic and difficult experiences they had whilst in the military, although I had not asked about this. There were many annotations within the interviews of times that participants had coped with physical or environmental hardship with resilience. This quote by Danny provides an example of this,

> The guard room was attacked and they planted a bomb outside it. Well I was on duty that night and the whole wall came in, and me and my mate was buried under the rubble. So once we were dug out I think we was both fine, no problem at all, just dirty and dusty. Cuts and grazes but you know, we didn't really notice them.

In my journal I had reflected on what it meant that participants were telling me this information in addition to information about managing PTS. Firstly, participants may have presented this information to give context, since I am a civilian with no military experience. Secondly, I had a sense that it was about gaining recognition for what they had endured, and to recognise their resilience as a balance to the vulnerability they showed when discussing situations where they felt they had less power and control. Discussion with my research supervisor validated this link as plausible, and we concluded it would be good to compare what I had found with previous research literature. My reflections fitted with research stating that distress is more easily tolerated in soldiers who have established a reputation as effective and competent (Green et al., 2010). When narratives are balanced and integrated, research suggests it is easier to renegotiate a positive identity (Demers, 2013; Burnell, Hunt, & Coleman, 2009). It may be that taking part in the research and having the space to talk about their experiences in this way was part of this process (Peel, Parry, Douglas, & Lawton, 2006).

My overall reflection was a sense that participants took part in the study so that their experiences could be used to help other veterans. To value their commitment to this and the time they gave, findings need to be disseminated widely throughout the veteran community. This will be done through producing an accessible summary of findings in addition to submitting the study article for publication, and by visiting the organisations that facilitated recruitment to offer a presentation of findings in person.

Conclusion

This critical appraisal has explored how military masculinity impacts on whether military personnel and veterans are able to access help and support that is valuable for managing mental health difficulties and problematic emotions. It has also looked at what can

be done to bridge the cultural gap between veterans and civilians, since reintegration within the community is considered essential to fully reintegrate into civilian life.

Future directions suggested within this appraisal include providing avenues for peer support in the military outside of working relationships, and having better links between military and veteran community organisations so informal peer support can be accessed during the transition out of the military. Catching difficulties with emotions early may help veterans to accept and talk about difficulties without their situation gradually deteriorating to 'rock bottom'. Alternatives to masculine socialisation during training of military personnel need to be considered due to the damaging effect that is has long-term on some veterans' mental health. Veterans' community organisations and charities could aid reintegration with civilians by encouraging engagement between the two groups and producing a campaign to help the public understand veterans better. The findings of the current research will be most useful if they are widely disseminated within the veteran and civilian community.

Overall the literature review and empirical study findings presented in this thesis add depth and explanatory value from veterans' perspectives, to what is predominantly a quantitative literature base.

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Section Four: Ethics Documents

Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Ethical Approval for Research

for additional advice on completing this form, hover cursor over 'guidance'.

Guidance on completing this form is also available as a word document

Title of Project: An interpretative phenomenological analysis of how Veterans successfully manage post-traumatic stress

Name of applicant/researcher: Gemma Parry

ACP ID number (if applicable)*: **Funding source (if applicable)**

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist on DClin programme

2. Contact information for applicant:
E-mail: g.parry2@lancaster.ac.uk **Telephone**: 07735501969 (please give a number on which you can be contacted at short notice)

Address: Clinical Psychology, Faculty of Health and Medicine, Furness Building, Lancaster University, Lancaster LA1 4YG

3. **Names and appointments of all members of the research team (including degree where applicable)**

Gemma Parry BSc (Hons)

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following

the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant: Dr Suzanne Hodge

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**: Lecturer and Research Supervisor, Health Research, Lancaster University

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management

For additional guidance on data management, please go to Research Data Management webpage, or email the RDM support email: rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' n o
4c. If yes, where relevant has permission / agreement been secured from the website moderator? n o
4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? n o

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.

6a. Is the secondary data you will be using in the public domain? n o
6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder
7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

On leaving the Armed Forces many Veterans find that the stress of extreme events they witnessed or took part in as part of their job continues to affect them on their return to civilian life. The common name for this experience is post-traumatic stress. Some Veterans with this experience have found ways to cope well with it, and to adjust into a life with a high level of purpose and wellbeing. It is important that these experiences are noted because it will help form a better understanding of whats important for recovery or management of PTS in Veterans. The project will involve recruiting Veterans with experience of managing PTS successfully, through voluntary organisations who provide support to them. Participating will involve being asked in detail how participants made sense of and managed PTS. The accounts will be examined for key themes, which will be presented in a report.

2. **Anticipated project dates (month and year only)**

Start date: October 2017 End date: September 2018

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The study aims to recruit between 6 and 12 participants.

Inclusion Criteria

- Participants will be Veterans (ex-members of the Armed Forces) at least 12 months post-discharge.
- Participation will not be limited by gender or job role.
- Participants will live in the UK and be English speaking. A translator may be requested to interview non-English speaking Veterans if essential to carrying out the research.
- Participants will have experienced PTS; broadly defined for recruitment as stress directly related to events witnessed or experienced during their work in the Armed Forces which has impacted on wellbeing and functioning on return to civilian life. As the researcher wishes to avoid medicalising the concept of PTS, the experience of certain symptoms or a diagnosis of PTS disorder (PTSD) will not be specified as essential. However, participants will be asked during the interview what their understanding of PTS is, to ensure some consistency in the experience across those included.
- Participation will be requested from those who feel they have had success in managing, coping or recovering from some aspect(s) of PTS and the impact it has had on re-adjustment into civilian life. This will be self-defined, since experience of managing, coping and recovery cannot be objectively judged or measured by the researcher.

Exclusion criteria

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

A standard email /social media advertisement for the study has been created to invite participants to take part (Appendix 1). This contains an expression of interest form for participants to request further detail by phone, post or email.

Recruitment will involve contacting the following organisations requesting that they distribute the study advert to members through email, social media, displaying the study advertisement in their base, or any other preferred method of the organisation:

[redacted]

Either the researcher or the field supervisor already has contact with the above organisations.

On contacting the main researcher potential participants will be given the information sheet (Appendix 2), and have the opportunity to ask questions before deciding whether to take part. Where relevant, an interview will be arranged at a time convenient for both the participant and the researcher.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

The research is qualitative and will involve conducting semi-structured interviews with Veterans about their experiences of managing post-traumatic stress following discharge from the Armed Forces. There will be some commonality in the topics discussed but flexibility for participants to lead discussions based on factors most relevant or important to them. Interpretative Phenomenological Analysis (IPA) will be used for analysis, as the project involves making sense of experiences of veterans, from the perspective of a researcher who is outside of this homogenous group.

Fieldwork will involve arranging interviews at a time and location convenient to participants and the researcher. Participants will have the choice to be interviewed in person, by phone or over Skype. If using Skype participants will be informed that the researcher is not able to guarantee security of the application and it will be checked whether they are willing to proceed in this way. Interviews will last approximately 60 minutes and will be audio recorded.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.

Expression of interest forms will be scanned and kept in an encrypted file on the university secure server. Paper copies will be destroyed immediately and the electronic copies will be retained only until participants have been interviewed, or have informed the researcher that they do not wish to take part. If participants wish to receive a summary of the research at the end of the study, their details will be retained until this summary has been sent out.

Following each interview the audio file will be saved in an encrypted file space on the university server as soon as possible and then deleted from the recorder. It will be deleted from the university server once the project is complete. The interview recordings will be transcribed by the researcher and stored under password protection on the university secure system. They will be anonymised by use of participant ID numbers, and the

corresponding identifying information will be stored separately from the audio recordings and transcripts. Consent forms will be scanned and scanned files kept separately from recordings and transcripts on the university secure system. Paper copies will be destroyed after scanning. The researcher and research supervisor will have access to this data during the study, and the researcher will have responsibility for all data stored.

Once the project has been completed, data will be encrypted and transferred securely to the research coordinator, who will save the files in a password protected file space on the university server for long term storage. They will take responsibility for the data at this point.

7. Will audio or video recording take place? ☒ no ☒ audio ☐ video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

Participant interviews will be stored on an audio recording device on the day of the interview. The recording device will be transported in a locked case to the researchers home, where the recording will be transferred to the university secure system via the virtual private network (VPN) and deleted from the recorder as soon as possible. The recordings will be deleted from the secure system when the study has been completed.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Once the project has been completed the data will be transferred in encrypted format to the DClinPsy research co-ordinator for long term storage. All data will be deleted after 10 years.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?
N/A

8b. Are there any restrictions on sharing your data ?
N/A

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?
The researcher will obtain informed consent from each participant on the day of participation, before commencing the interview. Participants will be invited to ask questions or share concerns prior to completing the consent form. Participants will complete two hard copies of the consent form. The researcher will sign both copies, and each will keep a copy. It will not be necessary to assess capacity of participants.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

It is possible participants may become distressed whilst discussing their experiences of PTS and its management, or following the interview. Participants will be debriefed, including signposting towards one of the following avenues of support, which will be noted in the information sheet for the study:-

- Their GP or mental health professional (where applicable)
- Samaritans 24-hour freephone support line
- Contacting emergency services or attendance at A&E if at urgent risk of harm to self or others.

Veterans may also be signposted towards local community support services for Veterans, such as those aiding recruitment.

Participants will be informed that they can withdraw from the study at any point and can ask for their data to be removed until the point of submission to the University.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

The researcher will meet with participants at public locations where there is a private space available (such as Lancaster University or the base of the military organisations who aid recruitment, [redacted]. The researcher will nominate a contact person who will be informed of interview dates, times and locations, reducing the risk of lone working. The researcher will not visit participants at their homes.

It is possible that the interview could cover material which the researcher finds distressing. The researcher will discuss this with the project supervisors in the first instance if this is the case.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

Increased theoretical understanding of how Veterans successfully manage PTS may lead to developments in policy or practice in services provided to Veterans. However, this is not the aim of the study.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:
None

14. Confidentiality and Anonymity
a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?
yes
b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.
Participants audio recording and transcript files will be numbered according to participant identifiers which will be stored in a separate file in a separate space of the secure server. Electronic versions of the consent form will also be stored separately to the recordings and transcripts.

Confidentiality will be limited where information given indicates possible or actual harm to self or others, and this will be stated in the information sheet. Information would be share with project supervisors to decide the best course of action, e.g. contacting emergency services where there is immediate risk of harm to the participant or a member of the public.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

Eight Veterans from [redacted] were consulted on research they thought would be valuable in the area of post-traumatic stress. Discussions centred around struggles successfully managing PTS and what 'cracked it' for them. Three Veterans used this wording, and further group members used language such as 'what did it' or 'what seemed to help'. They felt this could help non-Veterans understand their experience and may help other Veterans in future.

[redacted] has been consulted on materials produced for the study, including the information sheet, study invite and interview prompt sheet. He will be available for further consultation as needed.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

Findings will be detailed in a report for submission as a DClinPsy thesis. It will then be submitted for publication in an academic journal.

A summary of the research findings in accessible language will be distribution to participants if desired, and to organisations who aid recruitment or may find the information valuable.

Findings will be presented to DClinPsy trainees and staff, and may be presented at an appropriate conference related to the subject area.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

SECTION FOUR: signature

Applicant electronic signature: Gemma Parry Date 27/06/17

Student applicants: please tick to confirm that you have discussed this application with your supervisor, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): Dr Suzanne Hodge Date application discussed 27/06/17

Submission Guidance

1. Submit your FHMREC application by email to Diane Hopkins (d.hopkins@lancaster.ac.uk) as two separate documents:
    i. **FHMREC application form.**
    Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line*.
    ii. **Supporting materials.**
    Collate the following materials for your study, if relevant, into a single word document:
        a. Your full research proposal (background, literature review, methodology/methods, ethical considerations).
        b. Advertising materials (posters, e-mails)
        c. Letters/emails of invitation to participate
        d. Participant information sheets
        e. Consent forms
        f. Questionnaires, surveys, demographic sheets
        g. Interview schedules, interview question guides, focus group scripts
        h. Debriefing sheets, resource lists

    Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:
    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Diane Hopkins **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.
    ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:
        a. existing documents/data only;
        b. the evaluation of an existing project with no direct contact with human participants;
        c. service evaluations.

3. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

Doctorate in Clinical Psychology | Lancaster University

Thesis Research Protocol

An interpretative phenomenological analysis of how veterans successfully manage post-traumatic stress

Researcher:

Gemma Parry

Under the supervision of:

Dr Suzanne Hodge (Lancaster University)

Dr XXXXXXXXXXX

Introduction

Literature Review

Post-traumatic stress (PTS) in veterans following discharge from the Armed Forces is a common problem, with estimates of approximately 15-30% of serving military personnel affected (Department of National Defence, 2013)*. According to the National Institute for Health and Care Excellence (NICE; 2005) PTS develops following an 'exceptionally threatening or catastrophic' event and can involve re-experiencing the event through flashbacks, nightmares and intrusive thoughts, as well as general hypervigilance to threat and numbing of emotions. There is a strong physiological element, with anxiety, irritability, difficulty concentrating and poor sleep being commonly reported alongside the above experiences. Consequences of unmanaged PTS in veterans include adjustment problems, substance abuse, aggressive behaviour, breakdown of relationships and suicide (Braswell & Kushner, 2012). PTS is an increasingly prevalent issue within UK mental health services, with the Ministry of Defence (2016) reporting figures for assessment having risen from 1.8% of in 2007/8 to 3.2% in 2015/6. They acknowledge that the increase may indicate increased difficulties, as well as resulting from anti-stigma campaigns and increased awareness of help available.

Theoretical understanding of how veterans manage or recover from PTS after discharge from the Forces is a complex issue involving factors unique to veterans. For instance, a high proportion of veterans are male (90.1%; MoD, 2014a) and pressure may come from masculine role narratives that make it hard to seek help for emotional difficulties, increasing isolation and making recovery more complicated (Shield, 2016). Similarly, Cornish et al. (2014) found that veterans saw needing help with emotions as shameful internally and externally, and a challenge to their identity, strength and power.

It is important to consider that 'recovery' from PTS and its effects is a concept that is difficult to define, since it is likely a process alongside an outcome (Roberts, 2008), and has a

broader focus than just the absence of symptoms relating to a diagnosis (Craig, 2008). General qualitative literature on recovery from PTS suggests that it is a personal journey, with a unique combination of many factors that result in a change to attitudes, values, feelings and functioning over time (Phillips, 2012). The majority of PTS recovery literature in veterans has been quantitative. More recently qualitative studies have emerged in the literature, for example with a focus around reintegration into the civilian workplace (Kukla, Rattray & Salayers, 2015) and on experience of treatment (Hundt, Barrera, Arney & Stanley, 2017) or barriers in accessing it (Bunnell et al., 2017). A study by Adjukovicis et al. (2013) found that recovery from PTS following the war in former Yugoslavia included finding social attachment, support, strategies to manage symptoms, personal qualities, mental health treatment, practical support and normalisation in everyday life all to be important.

The researcher consulted with a group of eight veterans from XXXXXXXXXXXXX in August 2016 on what research they felt was needed for Veterans with PTS. Discussions centred on how it was a long journey, filled with struggles in recognising, accepting and coping with PTS, but they all felt something in particular helped them to 'crack' it. They felt it would be valuable for them to share this through research, stating that they were enthusiastic about helping others in future as well as helping civilians to understand what their experiences have been like. The main purpose of this research is consequently to build upon the qualitative research already carried out in the area of successfully managing PTS and develop further theoretical understanding using an in-depth qualitative methodology.
*US figures have been used as estimates of the number of discharged personnel with PTS, as it is not recorded in the UK (MoD, 2014b).

Research Question

How do veterans cope with PTS related to their experience in the Armed Forces?

Method

Design

The design of the study will be qualitative, involving semi-structured interviews. Interpretive Phenomenological Analysis (IPA) will be used to analyse the data.

Participants

Inclusion Criteria

- Participants will be veterans (ex-members of the Armed Forces).
- Participation will not be limited by gender or job role.
- Participants will live in the UK and be English speaking. A translator may be requested to interview non-English speaking veterans if essential to carrying out the research.
- Participants will have experienced PTS; broadly defined for recruitment as stress directly related to events witnessed or experienced during their work in the Armed Forces which has impacted on wellbeing and functioning on return to civilian life. As the researcher wishes to avoid medicalising the concept of PTS, the experience of certain symptoms or a diagnosis of PTS disorder (PTSD) will not be specified as essential. However, participants will be asked during the interview what their understanding of PTS is, to ensure some consistency in the experience across those included.
- Participation will be requested from those who feel they have had success in managing, coping or recovering from some aspect(s) of PTS and the impact it has had on re-adjustment into civilian life. This will be self-defined, since experience of managing, coping and recovery cannot be objectively judged or measured by the researcher.

Exclusion criteria

- Civilians, or veterans with no experience of the longer term effects of PTS and a journey towards recovery.

Sample Selection

Convenience sampling will be used, by sending a study advertisement to potential participants via community veteran focused organisations. The number recruited is likely to depend on the quality of the data obtained (Smith, 2004), however bearing in mind that the analysis is complex and elaborate the researcher will aim to recruit between 6 and 12 participants on a first come, first served basis. Recruitment will cease once all interviews have taken place.

Procedure

Recruitment of Participants

A standard email /social media advertisement for the study has been created to invite participants to take part (Appendix 1). This contains an expression of interest form for participants to request further detail by phone, post or email.

Recruitment will involve contacting the following organisations requesting that they distribute the study advert to members through email, social media, displaying the study advertisement in their base, or any other preferred method of the organisation:

- XXXXXXXX

Either the researcher or the field supervisor already has contact with the above organisations.

On contacting the main researcher potential participants will be given the information sheet (Appendix 2), and have the opportunity to ask questions before deciding whether to take part. Where relevant, an interview will be arranged at a time convenient for both the participant and the researcher.

Gaining Informed Consent

The researcher will ensure participants have a copy of the information sheet at least 24 hours before the interview. This will be emailed or posted, depending on participant preference. If by post it will be sent one week in advance and the researcher will check it has been received 24 hours prior to the interview. Participants will have opportunity to ask questions before the interview. The researcher will check participants are aware that the interview will be recorded, anonymised quotes may be included in the final report and they can withdraw their data at any point during or after participation, until the point of submission, when it will no longer be possible to remove it. The researcher will then check participants are prepared to continue, and if so they will be asked to provide written consent (form in Appendix 3) at the start of the interview.

Semi-structured Interview

A topic guide has been constructed (Appendix 4) to ensure certain topic areas are covered. Interviews will be conducted individually, lasting approximately 60 minutes. They will be transcribed verbatim.

Proposed Analysis

Data will be analysed using IPA, a qualitative method of analysis exploring how participants make sense of their experiences. Smith and Shinebourne (2012) outline the process as initially involving transcribing interviews and becoming immersed in the data through detailed exploration. Initial notes and observations are later transformed into emerging themes, to be looked at for connections and grouped according to conceptual similarities. It is an iterative process that involves returning to the transcripts throughout.

Practical Issues

The researcher will attempt to arrange a location to conduct the interview through Veterans organisations or Lancaster University if local for participants. Where it is not possible or practical to meet in person interviews can be conducted over the telephone or

skype, though participants will be informed that the researcher cannot guarantee security of Skype as an external application.

Materials required for the study (photocopies, recording and transcribing) will be provided by Lancaster University. Participants will be offered up to £20 for travel expenses incurred.

Ethical Concerns

Potential to cause distress

It is possible participants may become distressed whilst discussing their experiences of PTS and its management, or following the interview. Participants will be debriefed, including signposting towards one of the following avenues of support, which will be noted in the information sheet for the study:-

- Their GP or mental health professional (where applicable)
- Samaritans 24-hour freephone support line
- Contacting emergency services or attendance at A&E if at urgent risk of harm to self or others.

Veterans may also be signposted towards local community support services for veterans, such as those aiding recruitment.

Participants will be informed that they can withdraw from the study at any point and can ask for their data to be removed until the point of submission to the University.

Data Management Plan

Expression of interest forms will be scanned and kept in an encrypted file on the university secure server. Paper copies will be destroyed immediately and the electronic copies will be retained only until participants have been interviewed, or have informed the researcher that they do not wish to take part. If participants wish to receive a summary of the research at the end of the study, their details will be retained until this summary has been sent out.

Following each interview the audio file will be saved in an encrypted file space on the university server as soon as possible and then deleted from the recorder. It will be deleted from the university server once the project is complete. The interview recordings will be transcribed by the researcher and stored under password protection on the university secure system. They will be anonymised by use of participant ID numbers, and the corresponding identifying information will be stored separately from the audio recordings and transcripts. Consent forms will be scanned and scanned files kept separately from recordings and transcripts on the university secure system. Paper copies will be destroyed after scanning. The researcher and research supervisor will have access to this data during the study, and the researcher will have responsibility for all data stored.

Once the project has been completed, data will be encrypted and transferred securely to the research coordinator, who will save the files in a password protected file space on the university server for long term storage. They will take responsibility for the data at this point and will delete it after 10 years.

Time Scale

November 2017	Collect data and write SLR
December 2017	Literature review 1st draft
Nov 2017	Analyse data and prepare research paper draft
February 2018	Literature review 2nd draft
March 2018	Research paper 1st draft
April 2018	Research paper 2nd draft and Critical appraisal 1st draft
May 2018	Critical appraisal 2nd draft
May 2018	Submission
June- July 2018	Viva

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Appendix 1: Study Advertisement

Invitation to participate in:

A study of veterans' experiences successfully managing Post-Traumatic Stress

Do you have experience of post-traumatic stress related to your experience of working for the Armed Forces? Do you feel you have experience in managing the effects this has had on you and your life after being discharged?

If so do you feel you could share your experiences with a researcher, who aims to better understand factors that help veterans to live enjoyable and meaningful lives despite these difficult experiences?

Taking part would involve an interview lasting approximately an hour, which would be arranged at a time and location convenient for you, or over the phone / Skype if you prefer.

If you are interested in taking part please fill in the expression or interest form below which can be returned by post or email to:

Gemma Parry, Trainee Clinical Psychologist at g.parry2@lancaster.ac.uk or

Clinical Psychology Doctorate Programme Office, Faculty of Health and Medicine, Lancaster University LA1 4YG

Expression of Interest Form

Name:_____

Please provide at least one of the following and the researcher will contact you with further information:

Phone Number:_____

Email Address:_____

Postal Address:_____

Appendix 2: Information sheet

Doctorate in Clinical Psychology | Lancaster University

Participant Information Sheet

A study of veterans' experiences of successfully managing Post-Traumatic Stress

My name is Gemma Parry and I am conducting this research as a Clinical Psychology Doctorate student at Lancaster University. The project is being supervised by Dr Suzanne Hodge, Lancaster University and Dr XXXXXXXXXXX.

What is the study about?
Post-traumatic stress following experiences in the Armed Forces is a common experience. Veterans are a unique group, who face particular challenges that can make it harder to cope with post-traumatic stress, e.g. adjusting to civilian life which may be very different and feeling isolated among civilians who can't imagine what their experiences have been like. We know that many veterans do manage to cope with post-traumatic stress to live meaningful and enjoyable lives after discharge from the Forces. However we don't know how they manage the effects of post-traumatic stress in their lives, and what helps them to do this. This study aims to help build a better understanding by asking veterans to describe in detail what it was like for them and what has been most helpful.

Why have I been approached?
You have been approached because you are a veteran. I am interested in speaking to veterans who feel they have made progress in managing the impact of post-traumatic stress on their lives post-discharge and are willing to share their experiences in this area.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part.

What will I be asked to do if I take part?
If you decide you would like to take part, I will contact you to arrange to interview you at a time and place which is convenient for you. We will try to find a location to carry out the interview which is private but accessible to you. If you live outside North West England or North Wales it might not be possible for the interview to be done face to face. If this is the case, or if you prefer it, the interview can be conducted over the telephone or Skype.

You will have the opportunity to ask any questions you may have before the interview and will be asked to sign a consent form to take part. The interview will last for approximately 60 minutes and will be audio recorded and typed up.

Will my data be Identifiable?
Participant ID numbers will be used to store data on the university secure server to keep it as anonymous as possible. Only I and my supervisor, Dr Suzanne Hodge, will have access to the information you give us. The recording will be deleted once the project has been completed and the written transcript will be deleted after ten years. Consent forms containing your name will be scanned onto the secure server separately from your data,

paper copies will then be destroyed and electronic copies will be deleted after ten years. Quotes from your interview may be used in the reports or publications from the study. These will be anonymous and will not include any details which would identify you or anyone else.

The only limit to confidentiality would be where you mention something in the interview that makes me think that there is a significant risk of harm to you or someone else. If this happened I would discuss it with my supervisors, and if necessary, action would be taken to ensure the safety of you and others. Where possible, I will tell you if I have to do this.

What will happen to the results?
The information that you give will be looked at in detail, along with the information provided by other participants, to identify common themes. The results will be written up into a report which will be submitted to Lancaster University as part of my doctoral degree and for publication in an academic journal. A summary of the results will be written up and sent to organisations such as NHS services and community organisations who support Veterans. I will also send you a copy of this summary if you would like to read it.

If you decide at any point that you want your information to be removed from the study, every effort will be made to do this up until the point of submission to the University.

Are there any risks?
There are no risks anticipated with participating in this study. However, you might find it upsetting talking about difficult experiences. If you experience any distress as a result of taking part you are encouraged to let me know and to contact the resources provided at the end of this sheet.

Are there any benefits to taking part?
Although you may find participating interesting, there are no direct personal benefits from taking part.

Who has reviewed the project?
This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?
If would like to take part in the study or would like more information, please contact me using my details below:

Gemma Parry
Trainee Clinical Psychologist
Faculty of Health and Medicine
Lancaster University
Lancaster
LA1 4YG

Email: g.parry2@lancaster.ac.uk

Complaints or Concerns
If you feel distressed after discussing your experiences of managing post-traumatic stress please consider the following avenues of support:

- Contact your GP or out of hours service
- If you feel you or someone else is at risk of harm contact emergency services or attend your local A&E department
- The Samaritans operate a 24-hour support helpline which can be accessed free by calling 116 123 from any phone.

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Suzanne Hodge
Research Supervisor for the project
Email: s.hodge@lancaster.ac.uk

Professor Bill Sellwood
Programme Director
Email: b.sellwood@lancaster.ac.uk
Tel: 01524 593998

If you wish to speak to someone outside of the Lancaster University Doctorate Programme, you may also contact:

Professor Roger Pickup
Associate Dean for Research
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Tel: 01524 593746
Email: r.pickup@lancaster.ac.uk

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

Appendix 3: Consent Form

Doctorate in Clinical Psychology | Lancaster University

Consent Form

Study Title: A study of successfully managing Post-Traumatic Stress in veterans

We are asking if you would like to take part in a research project to explore veteran's views of what helped them to successfully manage post-traumatic stress following discharge from the Armed Forces.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal researcher, Gemma Parry.

	Please initial each statement
1. I have read the information sheet and fully understand what is expected of me within this study	☐
2. I have had the opportunity to ask questions and to have them answered.	☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.	☐
4. I understand that audio recordings will be kept until the research project has been examined.	☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	☐
6. I understand that once my data has been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of submission to the University / academic journal.	☐
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and published	☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events.	☐
9. I understand that any information I give will remain strictly confidential and anonymous unless I express a risk of harm to myself or others, in which case the principal investigator may need to share this information with her research supervisor.	☐
10. I understand that the information I give will be discussed with the researcher's project supervisors.	☐

	Please initial each statement
11. I consent to Lancaster University keeping written transcripts of the interview for 10 years after the study has finished.	☐
12. I consent to take part in the above study.	☐

Participant Name_____ **Signature**_____ **Date**_____

Researcher Name_____ **Signature**_____ **Date**_____

Appendix 4: Interview Topic Guide

Topic Guide for Interviews

- When did you serve? For how long? When discharged? Job role?
- What is your understanding of post-traumatic stress?
- What has this experience been like for you on your return to civilian life?
    - Prompts around impact on / relationship between PTS and adjustment, relationships, family, work, support received
- Please tell me about your experience of effectively managing post-traumatic stress.
    - Prompts around what helped – support from family, friends, NHS, community organisations, personal factors and journey
- Is there anything you think might help other veterans to manage PTS to reduce the impact on their return to civilian life?
    - Prompts around support from health services, community / voluntary services and from the Forces whilst in role and post-discharge.

Appendix 5: Ethics Approval Letter

Lancaster University

Applicant: Gemma Parry
Supervisor: Suzanne Hodge
Department: Health Research
FHMREC Reference: FHMREC16127

07 September 2017

Dear Gemma

Re: An interpretative phenomenological analysis of how Veterans successfully manage post-traumatic stress

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 592838
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Dr Diane Hopkins
Research Integrity and Governance Officer, Secretary to FHMREC.