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BRITISH VETERANS' NARRATIVES OF TRANSITION FROM MILITARY TO CIVILIAN LIFE

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Abstract

Transitioning from military service into civilian life is inevitable for all military personnel. Transition in this context refers to the period of reintegration from military to civilian life and involves all the changes that service leavers will experience when their career ends. The cultural differences between military and civilian life are underestimated, even from those who are well-prepared. The outcomes of transition, including social, health and occupational outcomes, are interconnected and may aid or hinder the successful management of reintegration challenges in the short-and long-term. Despite the numerous studies on military and ex-military personnel, which cover all aspects of transition and the continuous efforts to actively support the veteran community and facilitate the transition process, major barriers remain. In order to actively improve the transition process from military to civilian life, especially for veterans who suffer from ill physical or mental health, a deeper understanding is necessary. The main objective of this PhD research is to develop a 'Holistic Model of Military Transition' based on empirical research (UK-based) and theory. Drawing on veterans' life experiences allowed the development of a holistic and deep understanding of the unique challenges they face during both phases of transition (from practical problems to emotional imbalance) and the links between pre- and post-military experiences. This PhD includes three independent studies. The first study evaluated a new interview technique named Narrative Life Interview (NLI) by exploring the overall impact of the process on mentally traumatised military

veterans. Results indicated there are four key elements of NLI (structure, sharing negative as well as positive experiences, opportunity for self-reflection and obtaining a written copy of their narrative), which enhanced participants' psychological well-being through the process of narrating and sharing their life experiences in a safe environment. Practitioners, such as Clinical Psychologists or therapists, who work with an ex-military population, should be educated and aware of the military culture and the unique and complex process of transition. They should allow veterans to develop their own story, which includes positive as well as negative/traumatic experiences and allow for meaning-making to happen through reflection and growth in this therapeutic process. The second study explored the long-term impact of Competitive Motorsport on physically injured veterans' well-being. Results indicated there are five key elements (familiar environment, team spirit, adrenaline rush, competition, equality) that made Competitive Motorsport a unique experience for participants, which led to various psychological benefits, physical benefits, and the opportunity to socialise in a non-clinical environment with fellow veterans and civilians. Resettlement programmes and clinicians should be well-informed and be able to provide options and develop tailored plans to facilitate transition. Clinical interventions can promote involvement in safe, affordable and exciting physical activities or team sport, which will take into account relevant individual characteristics, such as physical limitations, coping styles or severity of symptoms and accomplish adaptive aims for the veterans. Future research in this area should identify the long-term economic and cost-benefit implications of recommending physical activity/sport, which will be

particularly useful for the improvement on the rehabilitation and resettlement plans of the military and NHS. The aim of the third study was to obtain a more sophisticated understanding of an under-researched topic, which is female spouses'/partners' perceptions of military transition. Results suggested there are multiple and complex challenges this population faces at a personal and interpersonal level (i.e., changes in couples' dynamics). Facilitators, such as interpersonal communication and tailored support, can lead to a healthier relationship and increased resilience against challenges. The study indicates the need for continuous improvements and additional support from health care services (e.g., NHS/Armed Forces charities), to reduce practical and logistical barriers in seeking help. Psychoeducation, raising awareness, sharing information and offering targeted guidance are necessary for spouses/partners to successfully navigate life after transition and effectively accommodate veterans with ill mental or physical health.

Dissemination/Publications

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Finally, for my third research project I would like to thank my participants individually for honestly discussing with me sensitive personal issues and helping me make this research become reality.

Dedication

I would like to dedicate this PhD to my dad and mum – mere words cannot explain how much I love you!

To my beloved grandfather, Fotis, who was honored by the Greek Government for joining Greek Resistance and bravely fighting against the Axis occupation of Greece in the period 1940 - 1945, during WWII. He passed away during my PhD, but he will always live in my heart. Love you grandpa!

Contents

Abstract *2*

Dissemination/Publications *5*

Acknowledgements *6*

Dedication *7*

Contents *8*

List of Figures and Tables *14*

Chapter 1: Literature Review *15*

1.1 Introduction **15**

1.2 Transition from Military to Civilian Life **18**

1.2.1 Issues Facing the Veteran Community 22

i. Mental Health 23

ii. Aggressive Behaviour, Criminality & Homelessness 36

iii. Physical Health 40

iv. Personal & Social Life 45

v. Employment 48

1.3 Help-Seeking Behaviours **51**

1.3.1 Stigma & Barriers to Care 51

1.3.2 Barriers to Care & Transition to Civilian Life 55

1.4 Theoretical Framework **57**

1.4.1 Self, Social Identity & Life Transitions 57

1.4.2 Military Environment 64

1.4.3 Psychology of Trauma 73

1.4.4 Narrative Approaches 77

1.5 Thesis Objectives 86

1.5.1 Thesis Chapters 89

Chapter 2 - Methodology 91

2.1 General Introduction 91

2.1.1 Population 91

2.1.2 Recruitment 92

2.2 Epistemological Stance 93

2.2.1 Qualitative Inquiry 93

2.2.2 Conceptual Terms 94

2.2.3 Methodological Justification 102

2.3 Data Collection 103

2.3.1 Qualitative Data - Interviews 103

2.3.2 Developing Interview Protocols 107

2.3.3 Psychological measures 109

2.4 Ethical Issues 113

2.5 Data Analysis 115

2.5.1 Qualitative Data 115

2.5.2 Thematic Analysis 115

2.5.3 Narrative Inquiry 121

2.5.4 Psychological measures 129

2.5.5 Generalisability 129

Chapter 3: Life Transitions - From Civilian to Military & Military to Civilian Life 132

3.1 Introduction 132

3.1.1 Research Aims 132

3.2 Part 1: Data from the Competitive Motorsport Study 134

3.2.1 Method 134

3.2.2 Results 136

3.2.3 Discussion 161

3.3 Part 2: Data from the Narrative Life Interview (NLI) study 165

3.3.1 Method 165

3.3.2 Results 170

3.3.3 Discussion 190

3.4 Conclusion 193

Chapter 4: Storytelling as an Intervention - The Narrative Life Interview .. 195

4.1 Introduction 195

4.2 Research Aims 195

i) The Narrative Life Interview 195

ii) The Narrative Construction of Reality 195

4.3 Method: The Narrative Life Interview 196

4.3.1 Study Design: NLI 196

4.3.2 Participants 197

4.3.3 Interview protocol 199

4.3.4 Psychometric Measures 200

4.3.5 Procedure 201

4.3.6 Narrative Analysis 203

4.4 Part 1: The Narrative Life Interview 203

4.4.1 Results: Follow-up interviews 203

4.4.2 Results: Psychometric Measures 207

4.5 Discussion 209

4.6 Part 2: The Narrative Construction of Reality 215

4.6.1 Story 1: Redemption Sequences & Narrative Identity 216

4.6.2 Story 2: Contamination Sequences & Narrative Identity 228

4.7 Discussion 240

4.8 Conclusions 245

Chapter 5: Sport as an Intervention for Physically Injured Military Veterans - The example of Competitive Motorsport 247

5.1 Introduction 247

5.1.1 Physical Activity & Military Veterans 248

5.1.2 Extreme Sport & Competitive Motorsport 251

5.2 Research Rationale & Research Aims 253

5.3 Method 254

5.3.1 Study Design 254

5.3.2 Participants 254

5.3.3 Interview protocol 256

5.3.4 Psychometric Measures 257

5.3.5 Procedure 257

5.4 Data Analysis: Qualitative Data 259

5.4.1 Results: 1st set of interviews 259

5.4.2 Results: Processing & Reflection (Follow-up interviews) 269

5.5 Results: Psychometric Measures 272

5.6 Discussion 274

5.7 Conclusions 283

Chapter 6: Family Reintegration - Experiences & Insights of British Military Veterans and their female Spouses/Partners 285

6.1 Introduction 285

6.1.1 Family Reintegration: Military Veterans 285

6.1.2 Family Reintegration: Veterans' Spouses/Partners 286

6.2 Research Aims 290

6.3. Method 291

6.3.1 Study Design 291

6.3.2 Participants 291

6.3.3 Interview Protocol 293

6.3.4 Procedure 293

6.4 Data Analysis 294

6.5 Prelude to Results: Veterans as Husbands/Partners 295

6.6 Results: Spouses/Partners of Veterans 297

6.6.1 Struggling to Adapt 298

6.6.2 Adapting to Struggle 305

6.7 Discussion 311

6.8 Conclusions 316

Chapter 7: General Discussion & Conclusions 317

7.1 Introduction 317

7.2 British Veterans' Narratives of Transition to Civilian Life 317

7.2.1 Needing a Purpose & Sense of Identity 321

7.2.2 Finding Purpose & Developing a Strong Sense of Identity 324

7.2.3 Loss of Purpose & Sense of Identity 325

7.2.4 Seeking Purpose & Efforts to Re-shape a sense of Identity 331

7.3 Social Support 339

7.4 Life Transitions & Sense of Identity 343

7.5 Beyond Conventional Therapies & Healthcare 346

7.6 Conclusions 352

References 356

Appendices 395

List of Figures and Tables

Figure 1 Military Transition Theory (Castro, Kintzle, Hassan, 2014) *65*

Figure 2 The cyclical pattern of pride *191*

Figure 3 The cyclical pattern of transition *319*

Figure 4 The cyclical pattern of the sense of identity *320*

Table 1 What Is a Veteran? *16*

Table 2 Issues Facing the Veteran Community *23*

Table 3 Themes Chapter 3/Part 1 ..... *136*

Table 4 Themes Chapter 3/Part 2 ..... *170*

Table 5 NLI Participants' Demographics *198*

Table 6 Themes Chapter 4/Part 1 ..... *204*

Table 7 T-Test NLI *208*

Table 8 Participants' scores *216*

Table 9 Redemption Sequences *220*

Table 10 Life-Story Constructs of Narrative Identity *222*

Table 11 Contamination Sequences *233*

Table 12 Life-Story Constructs of Narrative Identify *235*

Table 13 CM Participants' Demographics *255*

Table 14 Themes Chapter 5 ..... *260*

Table 15 T-Test CM *273*

Table 16 Participant Demographics (Spouses/Partners) *292*

Table 17 Themes Chapter 6 ..... *298*

Chapter 1: Literature Review

1.1 Introduction

The UK Armed Forces comprises the British Army, Royal Navy, Royal Air Force and Royal Marines. UK Forces personnel is calculated at 190,750, including trained UK regular personnel at 143,430, Volunteer Reserve at 36,430, Gurkhas at 3,070 and other personnel at 7,820 (MoD, 2019a). More specifically, UK Army Regular Forces is calculated at 78,360, Royal Navy/Royal Marines at 32,380 and Royal Air Force at 32,690. The total strength of the UK Forces has decreased between January 2018 and 2019 by 2.2% (i.e., 4,200 personnel). This decrease is part of a long term trend for the UK Regular Forces (MoD, 2019a). Even though the roles within the Armed Forces vary, most involve deployment away from home. Service personnel may work in humanitarian operations, be part of peacekeeping activities, or get involved in active combat. Serving in conflict is the most challenging role, as military personnel may experience coming under attack, directly firing at the enemy, civilian hostility, suffer physical injuries or handle human remains (Sundin et al., 2014). It was estimated that 6 in 10 veterans (i.e., 58%) had been deployed on overseas duties, consisting of both combat and non-combat roles (Johnson & Murariu, 2015; Jones et al., 2014).

a) Understanding of the term 'Veteran'

The word '*veteran*' has different definitions in different countries, based on what ex-service members need to have accomplished to be considered as deserving of veteran status. Sometimes publics and governments can define

veteran populations in different ways. The general public may have different views on what ex-service personnel need to have accomplished to deserve this title (e.g., serve in active deployment). This choice can affect not only the number of veterans that a government will generate, but also the policies that will be designed to deal with veterans' affairs (Dandeker, Wessely, & Iversen, 2006). In their study, Dandeker et al. (2006) summarise potential definitions in four ideal typical possibilities (Table 1, retrieved from Dandeker et al. (2006) in descending order of inclusiveness.

Table 1 What Is a Veteran?

Definition	Advantages	Disadvantages
1. All personnel who have served more than one day (and their dependents)	• Clarity • Appeals to recruits	• At odds with service • Public opinion • Cost
2. All personnel who have completed basic training	• Less inclusive • Fairer	• As above
3. All personnel who have completed one term of engagement	• Closest match to public/ charities opinion	• Excludes the most vulnerable
4. All personnel who have served in an active deployment	• Pleases the public • Perceived to be a clear role of the Ministry of Defence	• Difficult to define active deployment

The UK government selected the most inclusive definition available (definition 1) in terms of the options outlined in Table 1. This selection is important since it will be used as a platform to develop the strategy that will address military veterans' concerns. This inclusive definition can have various advantages, such

as the design of flexible packages of benefits, or an increase in recruitment incentives. However, such a broad definition may stretch resources so thinly that it will lead to social inclusion and neglect of the most vulnerable veterans. It is clarified that for the purposes of this PhD research, participants are 'veterans' who have served more than one day (i.e., Definition 1).

In 2017, the veterans' community was estimated to be around 2.4 million UK Armed Forces Veterans in Great Britain, making up an estimated 5% of household residents aged 16 and over (MoD, 2019c). It is projected that this number will decrease year-on-year and in 2028 there will be approximately 1.6 million UK Armed Forces veterans residing in Great Britain (MoD, 2019b). More specifically, the '*Population Projections'* report (MoD, 2019b) states that for every 80 veterans residing in Great Britain in 2028, it is projected that 35 veterans will be of working age (i.e., 16-67 years old), and 45 veterans will be of retirement age (i.e., 67+ years old).

b) Understanding of the term 'Military Family'

Apart from veterans, as independent individuals, the ex-service community also includes dependants, such as spouses/partners and children. Defining a 'military family' is not only key for military family health research, but also allows military and government policy makers to restrict access to services or benefits, which may have increased demand (e.g., healthcare or housing) (Gribble et al., 2018). For example, in the '*UK household survey of the ex-service community'* report published by The Royal British Legion in 2014 (RBL, 2014a), spouses/partners are defined as individuals who live as spouses of veterans

and are eligible for welfare assistance. Indeed, in the UK, there is no formally stated definition of '*military/veteran family*' and most definitions provided implicitly within policies that concern access to services or benefits. However, both traditional nuclear families (i.e., spouse/partner and children) and non-traditional families (e.g., unmarried or same-sex couples) are considered with policy definitions (Gribble et al., 2018). One of the studies of this PhD research (Chapter 6), explores the subjective experiences of veterans' spouses/partners during their husbands'/partners' transition to civilian life. Thus, the term '*spouses/partners*' used in this PhD, includes female individuals, who are/were married or in a relationship with a '*veteran*' (this term is described in the above section), rather than individuals who meet particular eligibility criteria for accessing services/benefits from military services.

1.2 Transition from Military to Civilian Life

Transitioning from military service into civilian life is inevitable for all military personnel as very few serve until full retirement (usually higher ranks). Regardless of whether they leave after serving a few years or the full term (22 years) until their retirement, transition is the period of reintegration from military to civilian life and involves all the changes that service leavers will undertake when their career ends. The majority of personnel leaving the Armed Forces do well after leaving (FiMT, 2013; HoP, 2016), yet there is a significant minority of individuals, including those with poor mental or physical health, who are at higher risk of becoming unemployed or socially excluded after leaving (Johnson & Murariu, 2015; Samele, 2013). Transition experiences

vary greatly among military personnel depending on their personal experiences and the definition of a 'good transition' remains undefined. For that reason, Forces in Mind Trust and stakeholders (FiMT, 2013, p.13) developed a definition:

"*A good transition is one that enables ex-Service personnel to be sufficiently resilient to adapt successfully to civilian life, both now and in the future. This resilience includes financial, psychological, and emotional resilience, and encompasses the ex-Service person and their immediate families*."

The processes to facilitate transition are set out in detail by the MoD (MoD, 2015). Around 20,000 military personnel form the British Army, Royal Navy and Royal Air Force, leave the UK's Armed Forces each year. Many of those individuals have had their lives enriched by their service, and they transition into civilian life, together with their families, without significant challenges. Finding appropriate ways to support service personnel in making successful transitions to civilian life is widely recognised as a priority for public policy and research.

The cultural differences between military and civilian life can be underestimated, even from those who are well-prepared (Fear et al., 2009). The experience of transition can vary greatly among service leavers, as it is significantly influenced by many factors described in both British (KCMG, 2014) and American (Castro, Kintzle, & Hassan, 2014) literature. These are military cultural factors (e.g., type of military discharge), personal characteristics (e.g., mental/physical health), the individual's preparedness (e.g., financial awareness) and attitudes to transition, the wider social context and civilian

perceptions of ex-military personnel, as well as the quality and consistency of support during and after transition (e.g. relevant services and family). The outcomes of transition are interconnected and may aid or hinder the successful management of reintegration challenges in the short-and long-term. These outcomes can be essential components to assess the quality of the transition and include social, health and occupational outcomes, such as adjustment to new family roles, engagement in the community, maintaining health and finding adequate employment. Transition can be challenging and influenced not only by the individual's attitude towards and preparation for their transition but also the way civilian society will welcome or not, the veteran population (FiMT, 2013). The problem of public perceptions acting as a barrier to the prospects of service leavers in civilian life and hindering recruitment into the Armed Forces has been highlighted in many official reports over the years (Ashcroft, 2012; KCMG, 2015, 2016). Lord Ashcroft's research in 2012 showed that 91% of the British public believed it was common for ex-service personnel to have been physically or mentally damaged by their military careers. This may not reflect the reality, but it implies that the Armed Forces do not effectively support service leavers for civilian life and do not raise the necessary awareness to the civilian population and employers. These are major barriers for veterans' transition, hindering their efforts to adjust in a personal and professional level (Ashcroft, 2012). Veterans can be valuable contributors to society and should not be considered as victims that is why ensuring a successful transition should be more than a matter of meeting the Armed Forces' obligations towards service leavers. The general public and

civilian employers should be able to associate veterans' greater skills and career prospects in civilian workplace (KCMG, 2016).

There are major domains that service leavers need to be informed about before starting their transition. Even service leavers who are well-prepared, mentally and practically, without having being subjected to violent incidents, being physically injured or mentally traumatised, may face the difference between military and civilian life as a surprise and a cultural shock (KCMG, 2014, 2015). Training and development are a big investment for the Armed Forces and it is important to ensure that service and ex-service personnel become valuable assets to society both when in active duty and as civilians (KCMG, 2015, 2016; Samele, 2013). Empirical evidence indicates that promoting holistic education into service personnel's resettlement programmes, such as employment courses, can raise financial awareness or preparation for family issues that may occur, can boost their confidence and, in turn, increase their chances of a smooth transition (Fear et al., 2009; KCMG, 2016). Civilian life has great financial demands and service leavers need to be well-prepared in advance and know how to do simple everyday tasks, such as finding a house and paying bills, to more complicated ones, such as where to look for employment, how to present themselves and their transferable skills and successfully develop their professional career (Kleykamp, 2013). Family, including spouse/partner, children, parents or siblings, is a strong and significant facilitator of transition in civilian life, yet, the members of the family are not well-informed and supported to effectively accommodate veterans' needs and facilitate their transition to civilian life (FiMT, 2013). Both the

government and society have a moral obligation and duty of care not only to ex-service personnel but their families, too. Even though the Armed Forces are trying to provide targeted resources in order to improve the consistency and quality of the transition process in all domains, it is still not as effective as it should be for a significant minority of the veteran population (FiMT, 2013; HoP, 2016; KCMG, 2016).

1.2.1 Issues Facing the Veteran Community

The last two decades have seen the Armed Forces exposed to the most intensive and sustained combat conditions, and the highest casualty rates since WWI, with a great increase in mental health research both within the UK and the US in order to improve the likelihood of successful transition by military personnel and their families into civilian life, unhindered by the prospect or the reality of physical or mental health problems (Samele, 2013). These latest conflicts in Iraq and Afghanistan reminded civilian society of the sacrifices that British military service personnel make, recognising the 'post-conflict dysfunction' that occurred (Iversen & Greenberg, 2009). This recognition has pushed the issue of service personnel's and veterans' health and well-being into military, political agendas and the public domain (Samele, 2013). The physical and psychological impact of these deployments in combat zones had on military personnel quickly become widely recognised as a public health concern (Demers, 2011; Polusny et al., 2011) and the negative health effects of the recent wars in Iraq and Afghanistan are well-documented (HoP, 2016; Iversen et al., 2011; Kapur et al., 2009). A significant minority of military

personnel who were deployed and served in these conflicts, were medically discharged due to physical injuries or mental health problems. For this population there is a greater risk of a complicated transition to civilian life, social exclusion and long term ill health (Fear et al., 2010; Iversen, & Greenberg, 2009) when there is lack of targeted guidance and support or the required additional assistance is not included in the resettlement package. Table 2 summarises the major issues facing the veteran community (Johnson & Murariu, 2015).

Table 2 Issues Facing the Veteran Community

i. Mental Health
a) Suicide & Self-harm
b) Substance Misuse
ii. Aggressive Behaviour, Criminality & Homelessness
iii. Physical Health (e.g., injuries, amputations)
iv. Personal & Social Life (e.g., unhealthy interpersonal relationships)
v. Employment (e.g., difficulties finding or maintaining employment)

i. Mental Health

Wars and combat are associated with mental health risk, including increased risk of suicide, depression, anxiety, symptoms of guilt and anger (Demers, 2011; Iversen, Dyson, & Smith, 2005), as well as high rates of post-traumatic stress disorder (PTSD) (Polusny et al., 2011). In turn, these conditions can challenge the individual's quality of life, emotional wellbeing, interpersonal

relationships and employment status (Fear et al., 2010). In times of war, violence or killing may be considered normal, yet it is important to acknowledge that some military personnel, especially some individuals who experience combat for the first time, may feel 'unprepared' for it, regardless of their physical training (Litz et al., 2009). This could be due to the unexpected and ambiguous combat situations that may arise, such as being confronted with numerous moral or ethical challenges, which military personnel have to face and cope with for the first time (Litz et al., 2009). In particular, research suggests that direct, intense combat and exposure to traumatic events, such as witnessing atrocities, injuring or killing others (Maguen et al., 2009), can have a long-term negative impact on some individuals; it can be a predictor of PTSD symptoms (MacNair, 2002) or postmilitary violence to self and others (Hiley-Young et al., 1995).

A substantial amount of research has been conducted into the mental health of the UK Armed Forces during the last few years. UK studies that investigate and compare the mental health in the UK military and general population suggest that it can be broadly comparable (Fear et al., 2010; Fear et al., 2009; HoP, 2016; Hunt et al., 2014). Nevertheless, some studies indicate that combat military personnel are more likely to endorse symptoms of common mental disorders (CMD) compared to civilians. In particular, Goodwin et al. (2015) examined the prevalence of probable CMD in a serving UK military sample compared to a general population sample of employed individuals. Results indicated that the prevalence of CMD in UK combat military personnel was approximately twice as high as for male civilians. Regarding PTSD specifically,

even though it is not the most common mental health issue, combat troops and reservists are more likely to suffer from PTSD than other service personnel or civilians (KCMG, 2016; Polusny et al., 2011; RBL, 2014b).

The most common mental health problems in the veteran population are depression, adjustment disorders, mood disorders, anxiety, alcohol/drug misuse, and personality disorders rather than PTSD (Iversen & Greenberg, 2009; Murphy, Iversen, & Greenberg, 2008; Walker, 2010). Iversen et al. (2005) investigated a representative sample of UK ex-service personnel at high risk of mental health problems and found that 43.8% had a psychiatric diagnosis. Depression affects around 480,000 veterans of all age groups, while around 370,000 report feeling lonely or are recently bereaved (Jones et al., 2014). Even though it is argued that most combat troops do not experience long-term issues as a result of their service, 1 in 25 UK regulars and 1 in 20 UK reservists will report a mental health problem or PTSD following deployment in Iraq and Afghanistan (Johnson & Murariu, 2015). Overall, research indicates that a significant number of service leavers may experience symptoms of PTSD, yet they will rarely experience them in isolation, more commonly they are co-morbid with a range of other difficulties (Murphy, Ross, Busuttil, Greenberg, & Armour, 2019).

King's College London's Centre for Military Research (KCMHR) undertook a large-scale ongoing investigation of the psychological and physical health and well-being of UK Armed Forces personnel. Around 16000 individuals have taken part in the cohort study since it began, including regulars and reservists personnel from all three Services (KCMHR, 2019). Many academic studies are

part of this three-phase cohort study. Fear et al. (2010) examined the psychological effect on the mental health of UK armed forces from 2003 to 2009, due to continuous combat exposure and repeated deployments. The study involving 8278 British regulars and 1712 reservists examined the consequences of deployment to Iraq and Afghanistan on the mental health of UK armed forces from 2003 to 2009. Results showed that the prevalence of symptoms of CMD was 19.7% and for PTSD was 4%. The third phase of this cohort study (2014/16) replenishment sample comprised 8581 individuals, 6915 regular and 1666 reserve personnel. Overall the results showed an increase in CMD (21.9%) and PTSD (6.2%) (Stevelink et al., 2018). Not only the intensity and frequency of combat, but also the soldiers' pre-deployment stressors, can be predictors of probable PTSD, yet PTSD remains less common in the military than either alcohol misuse or CMD (Andrews et al., 2009; Horesh et al., 2011).

PTSD among studies in the UK and the US remains a controversial subject as its prevalence varies enormously. For example, the prevalence of PTSD in UK and US troops serving in Iraq range from 1.4% - 31% (Sundin et al., 2010). Research on PTSD among military personnel indicates that the rates of CMD and PTSD in UK are lower than in US military personnel, even though similar measures of prevalence have been used (Hunt et al., 2014; Iversen & Greenberg, 2009). More specifically, only 7% of the UK combat troops fulfilled the diagnostic criteria for PTSD after returning from Iraq, comparing to 17.1% of the US combat troops (Hoge et al., 2004). The reasons why there is a difference in mental health issues between UK and US military personnel are still under

discussion. It is likely that differences such as demographics, the length of tour, combat exposure, culture, policies, or researchers' study design played a significant role (Sundin et al., 2010; Sundin et al., 2014). More than two thirds of the UK military personnel had been in a range of overseas operations before deployment in Iraq in 2003 (Hotopf et al., 2006). Yet, a similar study (Killgore et al., 2006) suggested that fewer than 10% of US soldiers have had previous deployment experience. Since UK troops were more experienced, they might have been more resilient to combat stresses and able to maintain a stable mental health status in the long term.

Even though the majority of individuals exposed to traumatic events are able to cope in the short-and long term, most of those who develop PTSD remain vulnerable to subsequent adversity. Results from a 20-year study on veterans from the 1982 Lebanon War (Solomon & Mikulincer, 2006) investigated the psychopathological effects of combat in veterans with and without combat stress reaction (CRS)[1]. Findings indicated that veterans with CRS were 6.6 times more likely to endorse (more severe) PTSD. Interestingly, findings also suggested that PTSD rates dropped 3 years post-war (for both groups of veterans), but rose again 17 years later, with 23% of veterans without CRS

[1] Combat stress reaction (also known as battle shock) is the most common acute reaction during combat. It can be seen as a specific type of acute stress disorder and the symptoms that characterised this condition include various psychiatric and somatic symptoms (e.g., fear of death, emotional and physical numbness, paralysing) (Department of the Army, 2009).

reported delayed PTSD. Another longitudinal study assessed 675 Israeli soldiers from the Lebanon war in 1, 2, and 20 years after the war (Karstoft et al., 2015), focusing on the association between the locus of control (LOC)[2] and coping style and the long-term PTSD-trajectories after exposure to combat. Results indicated that acute PTSD response, but also long-term PTSD outcomes can be affected by the ways individuals will cope with trauma; the use of problem-focused coping seemed to be an adaptive form of coping in this sample of veterans, opposed to emotion focused coping as maladaptive. Overall, findings from longitudinal and follow-up studies suggest that the detrimental effects of combat follow a complex course - they can be deep and enduring and the way each individual copes in the short and long-term can play a significant role.

Research indicates the importance of continued health surveillance of UK military personnel. In a recent study Murphy et al. (2019) reported evidence to show the applicability of a six-profile model (Low symptom profile, four Moderate symptom profiles and a Severe symptom profile) to explain the heterogeneity of PTSD symptoms within UK veterans seeking support for mental health difficulties. Membership in the profiles with greater PTSD severity was predicted by CMD. This evidence suggests the importance of

[2] Locus of control (LOC) is the degree to which individuals believe they can control events that affect them (Rotter, 1966).

moving away from a '*one-size fits all*' approach when it comes to treatments, but rather develop more tailored interventions which are informed not only by the diagnosis of PTSD, but also by the profile of PTSD symptoms and co-morbidities.

The majority of UK-based research focuses on the link between wartime experiences and post-deployment ill-health indicating combat trauma exposure as the main etiological factor. Childhood adversities or pre-enlistment traumatic experiences may also have a negative impact on psychological health across the lifespan and be a significant risk factor to develop psychological problems while or after military service (Iversen et al., 2007). Older studies on veterans with combat-related PTSD found a positive correlation between childhood adversity (e.g., sexual or physical abuse) and severity of PTSD (Engel et al., 1993; Zaidi & Foy, 1994). More recent studies in the UK and the US which examine pre-combat vulnerability and prevalence of mental health disorders and PTSD also support these results. For example, a study on 5324 US soldiers who served in Iraq and Afghanistan found that PTSD symptoms among the ones who reported combat exposure occurred in 12% of men (who reported prior assault) and 6% (who did not) and 22% of women and 10%, respectively (Smith et al., 2008). Iversen et al., (2007), based on 7937 regular UK military personnel, demonstrated that pre-enlistment vulnerability, such as childhood trauma, social deprivation, low education levels, is an important risk factor for post-combat ill health. Military veterans who have a history of adverse childhood experiences, can lead to high levels of psychopathology, when combined with deployment related traumas. A recent

study aimed to identify typologies of childhood adversity in 3092 US military veterans and explore relationships between the former and PTSD, mood and anxiety disorders (McLafferty et al., 2019). Even though individuals who experienced childhood adversities were less likely to have supportive social networks, an important finding was the significant mediating role of such networks, focusing on their quality, rather than the quantity.

Overall, longitudinal assessments of mental health problems show that research, which focuses only on the initial screening is likely to underestimate veterans' mental health burden, as in some cases there can be a substantial increase in mental health needs, even several months after returning from deployment (Milliken et al., 2007). This highlights the need to enhance military mental health care during and after this period as there is high risk for mental health problems to increase or be developed later on, on veterans' lives. Quality of social networks is a protective factor and it is important to raise awareness in order to develop and maintain social networks following military life by helping veterans enhance social relationships and engage back into the community (McLafferty et al., 2019).

a) Suicide & Self-harm

In recent years, even though studies in the UK (Kapur et al., 2009) and the US (Kaplan et al., 2007) indicate increased suicide rates among military and ex-military personnel, research examining suicide attempts and self-harm in the UK military or ex-military population is remaining limited (Harden & Murphy, 2018; Jones et al., 2019). Traditionally it was accepted that the risk of suicide

in military personnel was similar to the general population (Fear et al., 2009; Samele, 2013). According to Hotopf et al. (2006), 26-39% of returning UK veterans report experiencing significant mental health concerns, with more recent studies reporting a self-harm prevalence of 5.6% among UK military personnel, with the rate being 4.2% among serving personnel and 10.5% among veterans (Pinder et al., 2012). In the UK, evidence suggest that male veterans under the age of 24 have higher rates of suicide than the civilian population (Samele, 2013). More specifically, higher rates of suicide were reported for male military personnel, under 20 years old, that served between 1984 and 2007 (Fear et al., 2009). Another study explored suicide rates in UK veterans between 1996 and 2005 (Kapur et al., 2009), with results showing that from the 233,803 participants, 224 committed suicide during the study period. Comparisons between UK military personnel and civilian population show a lifetime prevalence of self-harm of 4.9% and attempted suicide between 4.4 - 5.6% (Bebbington et al., 2010). In their study Hawton et al., (2009) investigated 166 UK military personnel between 1989 and 2003 following self-harm report in a UK hospital. 72.3% of them were male and 62.7% were under 25 years. A recent study (Jones et al., 2019) sought to provide a contemporary account of UK military self-harm by comparing rates over time using cohort study data. Results showed that lifetime self-harm increased significantly from 1.8% among serving personnel and 3.8% among veterans in 2004/06 to 1.9% and 4.5% in 2007/09 and to 4.2% and 6.6% in 2014/16 in the two groups, respectively. Once again, ex-military personnel were consistently significantly more likely to report lifetime self-harm than

military personnel on active duty. Common reasons behind self-harm or suicide thoughts or attempts were usually poor social support, interpersonal or employment problems, mental health issues, stigmatisation and alcohol misuse (Jones et al., 2019). For example, a study which explored the risk factors of suicidal ideation in a population of 144 UK military veterans reported significantly higher suicidal ideation in early service leavers, veterans who were unemployed and those with a history of childhood adversity (Harden & Murphy, 2018). Indeed risk factors, such as lack of social support (reporting no close friends or family), troubled childhood (having adversity in family relationships or spent time in local authority care as a child) or adulthood (feeling angry or isolated or having fewer social activities), can negatively affect the life course of any individual (in military and non-military populations). However, studies suggest that deployment and traumatic combat experiences can be an additional trigger, which in combination with these risk factors, can increase self-harm and suicidal behaviours among UK and US service personnel (Elbogen et al., 2018; Hines et al., 2013; Wilks et al., 2019).

b) Substance Misuse

The consumption of alcohol is a feature of western society and evidence suggests that although there may be benefits from moderate alcohol consumption, excessive consumption and binge drinking can lead to detrimental effects on psychological and physical health and social life (FPH, 2017; Henderson et al., 2009; Singleton et al., 2003). Alcohol misuse rates also remains a controversial topic in the UK service and ex-service personnel.

Military culture has often been blamed for fostering excessive alcohol use, in the US and the UK military. An extensive literature review on alcohol use in the UK armed forces reports that medical opinions regarding the fine line between alcohol 'use' and 'misuse' are divided. Some doctors consider it as harmful for social and professional development, while others argue that when it is used with caution, it can add unit cohesion, lift morale or protect active duty military personnel from adjusting disorders (Jones & Fear, 2011). Military has to establish the balance between harmful and responsible alcohol consumption. Recent studies show high rates of alcohol misuse among UK military personnel, higher than the civilian populations, which may have both medical and occupational implications (Henderson et al., 2009; Hooper et al., 2008; Iversen, Waterdrinker, Fear & Greenberg, 2007; Murphy & Turgoose, 2019).

The 'Alcohol Use Disorders Identification Test (AUDIT)' was developed by WHO (World Health Organisation) as a simple screening tool to identify the early signs of harmful drinking and mild dependence (Bradley et al., 2007; Saunders et al., 1993). The WHO suggests that an AUDIT score of 8+ is an indication of hazardous drinking, thus a person may need support or benefit from an intervention (Room et al., 2005; WHO, 2001). Fear et al. (2007) used AUDIT to investigate drinking patterns in 8686 UK regular personnel. The study showed that 67% of men and 49% of women had an AUDIT score of 8+, compared to 38% of men and 16% of women in the civilian population. Military personnel on active duty will face new or unusual situations during their military career, they need to meet high standards of fitness in order to perform their duties with alertness and rapid response. In their study (Rona et al., 2010) explored

the association between alcohol misuse and functional impairment in a random sample of 8585 UK military personnel. Results showed that AUDIT score 20+, alcohol related harm, but mostly alcohol dependence were associated with functional impermanent. These findings indicate that alcohol misuse is an important health problem in the UK military because approximately a tenth of the sample had either an AUDIT score of 20+ or an indication of alcohol dependence which was consistently associated with functional impairment and almost half of those individuals had a possible psychiatric comorbidity. A longitudinal study (two phases) in 2015 investigated alcohol misuse in UK troops serving in 2003 (Thandi et al., 2015). These results also support previous studies showing high levels of harmful drinking in the UK military. Phase 1 (2004-2006) showed hazardous drinking in troops who suffered PTSD, were single or divorced. More specifically, 64.3% of men and 49.4% of women compared to 33.2% of male civilians and 15.7% female civilians. Decrease in scores during phase 2 (2007-2009) was associated with life improvements (e.g., reductions in PTSD or entering a new relationship). A decrease in the prevalence of symptoms of alcohol misuse from 13% to 10% was also found in the three-phase cohort study mentioned in the previous section (Fear et al., 2010; Stevelink et al., 2018). Overall research indicates that combat military personnel use alcohol as a resource to cope with stressors pre- and post-deployment, such as intense stress of combat, return from the battlefield to routine safety (Jones & Fear, 2011).

Further evidence suggests that alcohol misuse persists beyond military service, with prevalence rates for alcohol misuse higher in military veterans than the

general public (Craig et al., 2015). Treatment-seeking veterans have different patterns of alcohol misuse compared to the UK Armed Forces and the civilian population and they are more likely to report alcohol dependence and alcohol-related harm (Murphy & Turgoose, 2019). Socio-demographic characteristics are highly associated with alcohol misuse, such as relationship status (e.g., divorced, separated, single), family (e.g., an alcoholic parent, not having children), age (mostly young male), poor subjective body image or mental health, and smoking (Fear et al., 2007; Iversen et al., 2007; Jakupcak et al., 2010). Marriage and psychological interventions, such as CBT, have shown to be a protective factor in reducing heavy drinking (Johnson & Murariu, 2015). A study of 287 UK veterans who served in Iraq or Afghanistan showed that younger males or mentally traumatised individuals (e.g., depression, PTSD) were two times more likely to report alcohol misuse compared to the ones who were not positive to these disorders (Jakupcak et al., 2010). The Royal British Legion report (RBL, 2014a) also suggested that around 160,000 (23%) veterans aged 16-54 have an alcohol problem and only 5% over 65. Veterans between 35-64 years old are more likely to report depression or anxiety problems rather than alcohol misuse. Drug use is less common in serving personnel, however there some UK studies investigate drug misuse to ex-service community, focusing more on homeless or convicted of an offence (Fear et al., 2009). Research regarding drug misuse and mental illness is more extensive in the US but results should not be extrapolated in a UK context. Shipherd & Stafford (2005), in a prospective longitudinal examination of symptoms of substance use, also found that it was associated with

demographic characteristics and PTSD symptoms. More specifically, drug consumption appeared to be associated with 'self-medication' for mental health problems. This evidence is supported by other studies showing that alcohol misuse is commonly reported to be comorbid alongside CMD, PTSD, problems with anger and poorer long-term PTSD treatment response (Murphy, Ashwick, Palmer, & Busuttil, 2017; Murphy, Palmer, Westwood, & Busuttil, 2016).

ii. Aggressive Behaviour, Criminality & Homelessness

Due to the conflicts in Iraq and Afghanistan, there was increased attention on UK veterans' prevalence of aggressive or antisocial behaviour after returning from deployment (Fossey, 2010). Also, concern has been raised over the proportion of UK ex-service men in the Criminal Justice System (CJS) for violent offences, which is small yet significant (Lyne & Packham, 2014; RBL, 2012). Currently, the main part of the literature on post-deployment violence and aggressive behaviour has derived from the US, with the UK literature lacking research on the subject (Shortid et al., 2018). The Defence Analytical Service Agency (DASA, 2010) reported that there were 2,207 veterans in prison in 2009, representing 3% of the prison population, but the MoD estimated that 613 more veterans were in prison during this period, increasing the percentage at 3.5%. Even though the DASA report does not show veterans' length of service, the data provide information regarding the offence type compared with the general population. According to the report the ratio of veteran population (298.4 per 100,000) is lower than the civilian population (496.3 per

100,000), yet veterans' imprisonment is highly associated with violence and sexual offences (100.6 and 63.1 per 100,000, respectively) indicating that proportionally more veterans have committed these types of offences. Both violent and sexual offences account for 58% of all veterans' offences in the UK (RBL, 2012). More recent national data collected in 2015/16 show that from 62,397 cases, 1,067 (2%) reported previous service in the Armed Forces, and 48,578 had no previous service history (Shortid et al., 2018). The US Department of Defence research provides similar figures; veterans were also more likely to commit a violent offence (57% in 2004 vs 64% in 2012), rape or sexual assault (29% in 2004 vs 35% in 2012) (DoJ, 2004, 2015). A Ministry of Justice (MoJ) report analysed the data from the Offender Management Community Cohort Study (OMCCS) and the Resettlement Surveys (RS) and the key findings compared to the UK general population show that UK veterans in the CJS were more likely to be male, white and older, to have a qualification or have been in stable employment, or to have alcohol (and not drug) misuse problems (Kelly, 2014). The report concludes that offenders in veteran population have similar or lower levels of need than the general population, with the exception of alcohol misuse. However, a government review of UK veterans in the CJS highlighted the need for better identification of the needs of this population in the CJS to inform the development of services to help reduce re-offending (Phillips, 2014). Even though there are many charitable organisations to support veterans in the CJS, the majority of them were not aware at the time of the survey. Another MoJ report (Lyne & Packham, 2014) discusses the needs of UK veterans in the CJS comparing to the civilian

prisoners. Mental health needs were similar for both groups with the exception of depression, suicidal thoughts, self-harm, PTSD and identity issues, with high numbers reporting these issues. Recent studies also show that veteran status was associated with alcohol problems, physical health issues, interpersonal violence, motoring offences, anxiety disorders or unstable living arrangements, including homelessness (Shortid et al., 2018). Overall, veterans differ from civilians offenders in terms of their health, welfare needs and offending behaviour, and this could be a result of the impact of military service and the transition into civilian life (Shortid et al., 2018).

US-based research has shown that post-deployment violence is related to wartime and combat experiences (Black et al., 2005; Killgore et al., 2008) as well as pre-enlistment antisocial behaviour (Fontana & Rosenheck, 2005). Recent research has shown that a minority who become involved in the CJS experience health, behavioural and social problems. MacManus and colleagues investigated the prevalence of aggressive behaviour and violent offending on UK veterans who served in Iraq or Afghanistan. The reasons that may trigger veterans' aggressive behaviours, follow similar patterns as within the civilian population, such as subjected to domestic violence, low education level, unemployment or housing problems (MacManus et al., 2013; Macmanus et al., 2012a; Macmanus et al., 2012b). More specifically, notable risk factors associated with violent offending or antisocial behaviour on UK veterans can be:

- Childhood adversity
- Younger age
- Male sex
- Poor educational attainment
- Non-officer rank
- Pre-service offending
- Being a regular
- Increasing time spent on deployment
- Wartime experience: Combat role & exposure to traumatic events
- Post-deployment alcohol misuse
- Symptoms of PTSD

MacManus et al., (2012a) found a prevalence of violence of 12.6%, based on a large randomly selected sample of UK Armed Forces personnel. In a similar cohort study, 13,856 UK military personnel with a national criminal record took part (data was drawn from The Ministry of Justice Police National computer database) (MacManus et al., 2013). The results showed that 17% of male military personnel had a criminal record for any offence and 'violent offenders' (11%) were the most common types of offenders. The prevalence was higher in male military personnel aged 30 years or younger (20.6%) and decreased with age, when the prevalence of violent offenders in civilian population in the UK is 6.7% (<30 years old) and 8.7% (>46 years old). Deployment per se was not linked with increased risk of violent offending, however, serving in a combat role was (2.4% vs 6.3%, respectively). Soldiers who have been exposed to five or more traumatic events during combat were at higher risk to commit a violent offence (5.1%), than the ones who have been exposed to two or more

(4.1%), or zero to one (1.6%). Alcohol misuse is also significantly associated with aggressive behaviour and violent offending (9.0% alcohol misuse vs 2.3% no alcohol misuse). Finally, PTSD is also associated with 8.6% of veterans committing a violence offence vs only 3.0% with no symptoms of PTSD. More specifically, within the PTSD group, those who suffered from hyperarousal symptoms were most at risk of committing a violent offense.

Rates of homelessness among the veteran population have decreased from above 20% in the 1990s, to 6% in 2008 due to the improved resettlement programmes (RBL, 2010). However, UK service personnel, especially the ones in non-officer ranks, are concerned about housing issues during their resettlement programmes. The unfamiliarity with civilian life, housing markets or the welfare system can make it difficult for single veterans to secure housing (Jones et al., 2014). UK research shows that homeless veterans and civilians have the same characteristics. However, veterans are more likely to be single/divorced, older, have alcohol problems and sleep rough and there is some evidence that show a link between combat trauma, inability to cope with civilian life and being homelessness but more research is required (Johnson & Murariu, 2015; RBL, 2010).

iii. Physical Health

Even though the proportion of service personnel who die during operations has decreased the past decade due to technological and medical progression (Bellamy, 2007; Blood et al., 2002), the combat-related morbidity among military personnel returning from conflicts has increased (Holcomb et al., 2007). Apart from gunshot injuries, the increased use of improvised explosive

devices (IEDs) during the Iraq and Afghanistan conflicts, led to particular impairments (Breeze, 2012). More specifically, soldiers frequently experience serious injuries (e.g., head injuries, physical impairments) or amputations (Carless et al., 2013). The veteran population of working age is more likely than the civilian population to report having musculoskeletal problems, hearing difficulties, or some condition that limits their activity (Johnson & Murariu, 2015). However, the prevalence of other physical health problems, such as cancer, cardiovascular disease, Alzheimer's, or diabetes is similar to the general population (Woodhead et al., 2011). Over half of the adult veterans report some current illness or disability expected to last at least a year, while six in ten suffering from a long-term condition. Over half of veterans aged 25-44 with a long-term illness, such as musculoskeletal, hearing or psychological problems attribute it to military service (Johnson & Murariu, 2015).

As discussed in previous sections, combat-related trauma is a risk factor for mental and physical health problems (Forbes et al., 2012). Physical injuries can adversely affect mental health since they limit the individual's life, leading to potential psychological adjustment problems (Atherton & Robertson, 2006). It is not unusual for injured service personnel and veterans to also suffer mental health complaints and substance misuse that relate to their injuries (Demers, 2013; Koren, 2005). US- and UK-based research suggest that those injured during deployment have significantly higher rates of ill-health (e.g., depression, anxiety, PTSD), or alcohol misuse (Bryan et al., 2013; Wilk et al., 2010). There are many physical but also psychological issues underlying during the adaptation to a life with an impairment which may affect the well-being of the

individual (Gallagher & MacLachlan, 1999; Horgan & MacLachlan, 2004). An amputation that results from physical trauma is a sudden occurrence and sometimes an emotion-focused approach (e.g., avoidance) may be aimed at controlling the emotional response to the stressful situation (Coffey et al., 2009). A systematic review (Stevelink et al., 2015) explored a range of mental health disorders in (ex-) military personnel with a physical impairment. Overall, the papers included showed that mental health problems are prevalent, but rates vary considerably. More specifically, mental health disorders including PTSD vary from 2% to 59%, depression from 9.7% to 46.4%, anxiety from 16.1% to 35.5%, psychological distress from 13.4% to 36%, and substance misuse from 2.2% to 26.2%. Of note here, this review included studies from all over the world, with studies using a wide variety of diagnostic and screening measures were used, including data records and self-report, to identify a variety of mental health disorders. Such stressors may challenge veterans' ability to maintain emotional well-being leading to engender maladaptive reactions and poor psychosocial adjustment (Desmond & MacLachlan, 2006b). Other studies also indicate that health difficulties correlate with an increase in aggressive tendencies (Macmanus et al., 2012b), post-deployment adjustment disorders (Demers, 2011; Harvey et al., 2011), and social problems, such as poor family or personal relationships (Monson et al., 2009). Studies in civilian amputees indicate similar problems (Desmond & MacLachlan, 2006a). The prevalence of anxiety and depression were high. Distress and psychological adjustment difficulties were associated with activity restriction, prosthesis satisfaction and appearance-related beliefs and public self-consciousness.

The recent wars in Iraq and Afghanistan increased attention on Mild traumatic brain injury (mTBI) and post-concessional syndrome (PCS). Both mTBI and PCS have been referred as the 'signature injuries' for these wars, as 'shell shock' for WWI (Jones et al., 2014). mTBI is an acute brain injury and symptoms can occur following head trauma resulting from exposure to high-powered explosions or minor blows to head (Murphy et al., 2015). Symptoms of mTBI can be loss of consciousness, confusion/disorientation, fatigue, amnesia around the time of the injury, or neuropsychological impairment (Levine, 2010). PCS is considered to be the cause of long-term symptomatic ill-health and it is associated with psychological distress (Fear et al., 2009). The prevalence of mTBI in the US military who served in Iraq/Afghanistan is higher than in the UK military (Carlson et al., 2011) and research shows that the reported rate for mTBI is around 23%, and 59% in those sustaining a combat injury (Okie, 2005). Little is known about the rates of mTBI within UK veterans who are experiencing mental health difficulties (Murphy et al., 2015). In their study Rona et al. (2012) investigated the prevalence of mTBI in 4620 UK soldiers who served in Iraq or Afghanistan found that the prevalence was 4.4% and 9.5% for those with a combat role. Associations between mTBI, PTSD, alcohol misuse and multiple physical symptoms was also reported. Jones et al. (2014) also attempted to assess the rate of mTBI exposure and symptoms in 1363 UK troops deployed in Afghanistan in 2011; 5.9% reported one potential mTBI exposure and 1.6% reported an injury and more than one mTBI symptoms. Fear et al., (2009) examined associations with 'PCS symptoms' as an indication of the presence of mTBI in 5869 UK military personnel deployed

to Iraq. Results showed that 67% reported one or more PCS symptom(s) and 42% one or more moderate/severe PCS symptom(s). A small-scale study (Murphy et al., 2015) with 123 UK veterans also explored rates of TBI and symptoms of PCS. 63% of the veterans reported a TBI symptom. Even though there was no association between TBI and PCS, significant associations were found between TBI and suffering from mental health difficulties, such as anger issues or depression.

Rehabilitation programmes for UK military personnel have improved over the years, especially since conflict started in Iraq and Afghanistan. Soldiers who are amputees or physically injured often fear that their military careers will end or the opportunities for work and life enjoyment in general will be reduced (Carless et al., 2014). Some UK studies show that rehabilitation with vocational support can place some amputees back at work and that amputation does not necessarily mean the end of a military career (Dharm-Datta et al., 2011). However, multiple amputees usually opt out as there is a higher risk of a worse functional outcome (Krueger et al., 2014). The process of adaptation to limb amputation has many challenges. There may be impairments in physical functioning, prosthesis use and pain, phantom limb pain (Ketz, 2008), as well as changes in employment status, self-concept and body image, along with high levels of depression, anxiety and PTSD (Horgan & MacLachlan, 2004). That is why a single treatment does not work for all amputees. How patients perceive the effectiveness of different types of treatments suggest the need for individualised management plans. Even though the physical and pain consequences of injury contribute significantly to the maintenance of long-

term disability, psychological symptoms (e.g., depression, anxiety) play a greater role (O'Donnell et al., 2013). Early interventions targeting psychological symptoms, teaching new skills and improving patient's independence and mobility should be an integral part of rehabilitation as it will help to modify the previous bleak outlook of amputees (Singh et al., 2007). A holistic approach is more effective and will enhance amputees' quality of life in the long term (Zidarov et al., 2009). A study on 796 UK injured veterans, aged between 26 and 92 years, explored the link between coping strategies and psychological adaptation to amputation (Desmond & MacLachlan, 2006b). The results show that coping styles were important predictors of a more successful psychosocial adaptation. For example, 'problem solving' and 'seeking social support' led to a decreased depressive and anxious symptomatology and was positively associated with social adaptation. In contrast, there was a strong association between 'avoidance', psychological distress and poor adjustment. Studies in civilian population also show that coping skills can significantly affect quality of life after rehabilitation such as strong goal pursuit or goal adjustment (Asano, Rushton, Miller, & Deathe, 2008; Coffey et al., 2014).

iv. Personal & Social Life

After leaving the Armed Forces, ex-military personnel need to reconnect with their families and friends, but this is not a simple task. Veterans may struggle to reintegrate into social life and fit into civilian society. High levels of distress and tension exist among veterans and their family members as they sometimes feel misunderstood, caught between the military and civilian culture. These

feelings may alienate them from family and friends, leading to a crisis of identity (Demers, 2011; Herman & Yarwood, 2014; Sayers, 2011). The issues of social isolation and loneliness become increasingly recognised as public health hazards, which are approaching crisis levels. Research has shown that loneliness and social isolation are also linked to ill-mental and physical health (e.g., higher blood pressure, poorer sleep, depression) (Holt-Lunstad et al., 2015). Prevalence rates of loneliness and social isolation in the Armed Forces community are currently unknown. The Royal British Legion established a research project to explore those two concepts with a mixed-methods approach including more than 4,897 participants (RBL, 2017). Results indicated that 50% of survey respondents said exiting the Armed Forces caused them to feel lonely or socially isolated and one in four indicated that they feel lonely and socially isolated always or often. Moving to a new area and bereavement were also a significant cause of loneliness or isolation. Risk factors for loneliness, social isolation deterioration of health status or development of mental health problems can be complex and multifaceted. Different factors can lead to increased risk of these outcomes at different stages of life. A number of potential risk factors can be age, gender, relationship breakdown, existing mental health problems, physical injuries/disabilities or life transitions (RBL, 2017). Recent findings from the Office for National Statistics indicated that in the UK, civilian younger adults (16 to 24 years old) reported feeling lonely more often than those in older age groups (Pyle & Evans, 2018) and adults aged 45-54 have also reported high levels of loneliness (Beaumont, 2013). This trend is similar to the ex-Service community showing that the

middle-aged veterans aged 35 - 54 can be vulnerable to a range of problems (RBL, 2014a).

Depending on the individual's transition vulnerability to isolation or deterioration of mental health can be increased through the weakening of social ties or by threatening a person's sense of identity. Individuals may become withdrawn due to a range of barriers on individual, community and social levels depending on their situation and existing resilience (British Red Cross/Co-op, 2016). It is likely that current and ex-military personnel will experience an additional number of unique transitions compared to the civilian population, including joining up, deployments, combat and final exit from the military to civilian society (RBL, 2017). Research shows that potential factors which may protect individuals can be having a social network of friends and family, higher levels of education, having a personal confidant, pet ownership and spirituality (Adams et al., 2004; Parslow et al., 2005; Victor et al., 2005).

The impact of deployment or transition to civilian life on families of military personnel can be challenging. Most evidence is based on the international literature, as UK research on veterans' families, including female/male spouses, partners or children is lacking (Samele, 2013). US-based literature indicates that most families adapt and function well to the cycle of deployments, yet re-deployment or transition can have a negative impact, causing disruption to the family dynamic, such as lower life satisfaction for female spouses or mental health problems for children (Wiens & Boss, 2006). Conflicts in Iraq and Afghanistan had a greater impact on families leading to marital problems (Spera, 2009) and increased levels of stress and emotional or

behavioural difficulties in adolescents, as deployments were longer and more frequent (Rona et al., 2007). The MoD recognises the importance of the family during veterans' transition and resettlement, as a key factor for a successful new civilian life (KCMG, 2016). Even though the Armed Forces covenant discuss all the statutory services that families in the UK are expected to access (e.g., healthcare, education, housing), it seems that only voluntary services provide support for their emotional needs (Johnson & Murariu, 2015; Samele, 2013). Pre-existing problems and couple or family vulnerability may challenge family reintegration, especially if veterans are mentally or physically traumatised (Sayers, 2011). Difficulties that co-occur with veterans' transition include financial problems, relocation, child behavioural problems, loss of autonomy or issues with negotiating family roles. An additional challenge that may hinder the relationship and the couple as individuals can be veterans' mental issues (e.g., PTSD, depression), physical injuries and problems with rehabilitation (Drummet et al., 2003). The couple will need to re-negotiate basic household routines, strengthen joint problem-solving and decision-making abilities, and re-establish support networks (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008).

v. Employment

When veterans leave the Armed Forces, the main factors they consider are focused on their transition process and the 'quality of life' issues that may occur. Military involves training and education opportunities to service personnel, during service and as part of the resettlement support (i.e., first and

second line provision) to prepare them for transition into civilian life and employment (Kleykamp, 2013). An additional transition effort is 'The Career Transition Partnership' (CTP), which is available to all eligible ranks of the Armed Forces, such as full service is available for veterans who have completed 6+ years of Service or are medically discharged. CTP supports veterans to market themselves confidently to employers and succeed in the civilian job market (KCMG, 2016). Despite the efforts from the Armed Forces and the encouraging general outlook for veterans who entered the civilian job market after transition, major barriers still exist (FiMT/Deloitte, 2018). The BCL UK household survey of the ex-service community (RBL, 2014a) shows that one in six veterans (i.e., 300,000 people) of the working age (16-64) reports a problem, such as unemployment, fear of employment, lack of training or underpayment. Younger veterans aged 16-34 are particularly less likely to say they are able to use their acquired skills (four in ten) compared with seven in ten for the general population. Veterans aged 20-64 are also less likely to say they can use their skills and experience in their current job than civilians. Ex-military personnel who have served for fewer than three years tend to be less confident comparing to veterans who have been deployed or have combat experience, but the ones with qualifications are more likely to promote their work-related skills. The average income of the ex-service community as a whole, is estimated around £21,000 after tax and £15,900 for those aged 65 or over, which is below the national average for this age group. The annual population survey for UK Armed Forces Veterans (MoD, 2019c) showed that working age veterans were as likely to be employed as non-veterans (79% for

both groups). However, employment issues with younger veterans aged 16-34 remain. Young veterans were more likely to work as process, plant and machine operatives (18%), rather than in professional occupations (11%) compared to civilian population (8% and 20% respectively). Most service personnel join the Forces straight from school. When they leave, they have no subsequent experience of the civilian employment culture and processes, such as looking or applying for jobs (KCMG, 2016). Individuals aged 16-24 are more likely to have stopped studying at GCSE level, comparing to the UK average for their age. Three in four veterans have at least one qualification and eight in ten veterans who have served more than five years are likely to have an academic qualification (RBL, 2014a), which is an important tool while seeking for employment.

Veterans still struggle to gain a foothold in civilian employment due to misconceptions held by the civilian population (Poppyscotland, 2015). Many veterans continue to be stereotyped; either employers fail to recognise the transferable skills they have acquired during their service careers or veterans themselves are not able to successfully promote their skills, such as leadership, communication skills, teamwork and decision-making. A consequence of that is that many of them will work in low paid jobs or enter the skilled trades (e.g., technicians, builders) where the military's vocational training is more easily translated (Deloitte, 2016). A recent research survey (FiMT/Deloitte, 2018) suggested that 70% of veterans under 30 considered career progression as the most important factor when searching for civilian employment. On the other hand, finding the right job can be challenging, especially for those who live in

regions with fewer skilled job opportunities, such as areas of Wales, Scotland or the North of England. Location played a significant role as 51% of veterans chose not to move for a job opportunity and 78% would not commute over 60 minutes. Companies that have employed veterans are very positive about the value they bring and their ability to perform well across a range of areas, however, major employers suggest that barriers remain (FiMT/Deloitte, 2018). Although the majority of UK businesses claimed to be more open minded, 30% of them did not consider veterans when developing their recruitment strategies and 60% would not recruit someone with no industry experience (Deloitte, 2016).

1.3 Help-Seeking Behaviours

1.3.1 Stigma & Barriers to Care

As described in previous sections, military veterans have been acknowledged as a high-risk group for developing health problems, with evidence showing higher prevalence of both physical and mental health challenges in veteran compared with civilian populations (Ashwick & Murphy, 2017). Despite the increased risks, veterans have low rates of health service utilisation and go undiagnosed or untreated due to perceived practical barriers to accessing services (Richards, Goetter, Wojtowicz, & Simon, 2016). The stigma surrounding mental health continues to be an area of concern, with research indicating that the majority of military personnel delay or do not seek professional medical help (Iversen et al., 2010; Sharp et al., 2015). Military culture embraces strong masculine norms which can lead to difficulties for

individuals who challenge the culture by seeking help for mental health issues and the long-term consequences of not seeking help for mental health problems are well documented (Murphy et al., 2015). Major consequences of this were the development of negative beliefs regarding combat mental issues leading to lack of trust and confidence towards UK medical services. Evidence suggests that leaving the Army due to mental health issues can increase the difficulties during the transition to civilian life (Murphy et al., 2015). Previous studies have reported significant disparities between mental health difficulties and help-seeking behaviours, suggesting that a large number of veterans may not be receiving appropriate treatment and support (Iversen et al., 2010; Van Hoorn et al., 2013) and the ones who engage in treatment generally report modest gains compared to civilian population (Coleman et al., 2017). Yet a more recent study has indicated an increase in rates of ex-military personnel seeking help for mental health difficulties (Murphy et al., 2015).

There are several types of stigma and these are thought to interact with each other and contribute to barriers to help seeking. External stigma can be defined as a sign of disgrace, weakness, being untrustworthy and unreliable, setting them apart from their unit (Bolton, 2003). The Armed Forces consider stigma of mental health issues particularly problematic as soldiers are required to be psychologically and physically resilient (Rona et al., 2004). A systematic review of twenty studies between 2001 and 2014 examined the prevalence of stigma for seeking help and the evidence showed that approximately 60% of military personnel who experience mental health problems do not seek help. The two major concerns were that they may be seen as weak or be treated

differently (Sharp et al., 2015). Military personnel who perceived they have a mental health issue either sought informal support from family or friends, rather than medical help, or do not seek help for practical reasons, such as fear of being blamed for their mental issue or being unaware of where to ask for help (Iversen et al., 2010). Internal stigma can also be a key barrier for seeking help (Langston et al., 2010; Murphy et al., 2015). It may occur on its own or when veterans who experience mental health difficulties internalise the negative stereotypes and prejudices held by civilians (Vogt, 2011). Problems also arise when physically or mentally traumatised veterans are discharged from the medical care of the Armed Forces and have to rely on civilian health care services. Although the NHS has done much (e.g., promising priority for injured veterans) sometimes the veterans do not receive the care they are entitled to. After a nationwide campaign in 2016 (NHS, 2016), the NHS also recognised the importance of further improvements in its services for veterans. For example, feedback has highlighted the need to raise awareness of where veterans should go for help, accelerate treatment of early warning signs of mental health illness, alcohol and substance misuse as well as support the transition from armed forces healthcare to the NHS. Another issue was that health professionals had little or no experience of working with veterans showing the need to improve their understanding of the unique issues ex-servicemen face. Regional variations and demographic factors, such as socioeconomic status or deprivation have an impact on physical and mental health functioning. A recent study indicated that veterans from Northern Ireland took longer to seek help and had higher levels of physical health

conditions. Scottish and Welsh veterans seeking help from Combat Stress had a higher risk of smoking and alcohol misuse (Ashwick & Murphy, 2017). The findings show that a greater and more targeted focus needs to be placed on help-seeking veterans based on nation of residence and the specific challenges veterans face should be addressed in more detail in treatment programmes to be adequate.

Since WWI, veterans' charities have played an important role in the provision of health and welfare services for former military personnel and their families. There are numerous charities across the UK, which provide health and welfare services for veterans and their families and are very popular among the military community. Some major charities are Combat Stress, Help for Heroes, Blesma, Veterans Scotland and Blind Veterans UK. Armed forces charities have become increasingly important in providing health and welfare services for veterans and their families and advocating on behalf of both current and former armed-forces personnel on pertinent policy issues, such as The Royal British Legion campaigns. However, with the recent wars in Iraq and Afghanistan, the number of Armed Forces charities in the UK has grown rapidly, leading to concerns about quality and effectiveness, as not all of them report service evaluation findings (Gribble et al., 2014; Samele, 2013).

The multiple efforts of the MoD, the NHS and the Armed Forces charities targeted towards reducing stigma are acknowledged yet progress in this area remains limited and the increasing access to needed physical and mental healthcare among veterans and service members remains a persistent concern (Richards et al., 2016). A considerable amount of research has been conducted

on potential barriers to help seeking, such as the stigma of mental health, the individuals' perceived lack of need for treatment, negative treatment perceptions and logistical barriers – yet the relationship between them and the ways they affect individuals' help-seeking behaviours remains unclear with contradictory findings throughout the scientific literature. A recent report (Rafferty et al., 2017) involving sixty-two in-depth interviews with male UK veterans, indicated that although the mental health stigma was highlighted as a concern by all veterans, this did not translate to a significant impact on help seeking. The main reasons were veterans' inability to identify that they had a mental health problem and recognise their need for treatment, negative initial experiences with care, failure to engage successfully in mental health support due to eligibility issues and to waiting lists and to services being wrongfully withdrawn, even though veterans continued to experience significant symptoms which clinicians overlooked.

1.3.2 Barriers to Care & Transition to Civilian Life

The Transition Mapping Report (FiMT, 2013) discusses the causes of failed or poor transition highlighting that in 2012, failed transition costed the State £113 million. The report also provides recommendations which can effectively support the process, which include:

- Ensuring that ex-service personnel have the appropriate transferable skills or qualifications that are recognised by civilian employers and will help them to prosper in civilian life.

- Offering tailored support (e.g., increase civilian workplace and financial awareness) to help service leavers match their experiences and skills to their aspirations and be able to adapt on the challenges of civilian life.
- Engaging with and help the family during transition to act as a source of support when necessary.
- Investing to reduce transition risk by committing the available resources appropriately to reduce public and social costs of poor transition.

A successful transition is a combination of both external and internal support. Service leavers need practical resources, sufficient information and time to familiarise themselves with the civilian environment and way civilian life (FiMT, 2013; KCMG, 2016). Six years after the Transition Mapping Report and other official reports from relevant organisations (e.g., Arkenford & FiMT, 2017; FiMT/Deloitte, 2018; FiMT Report, 2014; KCMG, 2017) major barriers in all aspects of veterans' lives remain, including personal, professional life, mental and physical health (Defence Committee, 2018; Docherty-Hughes et al., 2019). The evidence suggests that the minority of veterans who suffer from mental or physical health conditions need timely and appropriate care. The revision and further development of the resettlement packages is necessary to support service personnel and their families to better manage the transition process in the short- and long-term, including information about the civilian workplace, how to find or apply for a job, financial advice, get fully informed regarding

civilian healthcare services or appropriate Armed Forces charities, where and how to access support.

1.4 Theoretical Framework

1.4.1 Self, Social Identity & Life Transitions

Erik Erikson is widely recognised as the originator of modern identity theories, although his model was developed to explain adolescent identity development (Erikson, 1968). The theory and its evolution highlights that individuals who manage to successfully shape an identity, develop a coherent, integrated sense of self, while failure to do so results in identity confusion or diffusion (Schlossberg, 2011; Schwartz, 2004). Individuals' identities are not static, they reshape in response to a variety of complex personal, social and cultural factors, especially during transitions that are on a level of identity disruption as it includes the challenge of re-organising the self-concept and integrating new identities into sense of self (Amiot et al., 2007).

Understanding human identity starts with thinking about the nature of self, even though the concept of self is difficult to define. Self is the essence of the individual, which distinguishes them from others. It provides "*a core structure within which social identities can change, develop, and become integrated intraindividually*" (Amiot, De La Sablonnire, Terry, & Smith, 2007, pp. 366). The theories of identity have been developed by taking into account the internal self and the roles the individuals have in the society. Humans are social beings and the most important expression of this sociality is that we live in social groups. Social groups are not simply external features which provide a setting

for human behaviour. Instead, groups have the capacity to contribute to the sense of self and shape individuals' psychology (Haslam, Jetten, Postmes, & Haslam, 2009). Individuals have multiple identities rather than a single identity because identities allow them to make sense of the world and their place in it. Identities include the beliefs and values that influence their behaviours and determine how to function well in a sociocultural environment, making it easier to fulfil an expected role and respond to life's challenges (Thompson et al., 2017).

Group memberships affect individuals' psychology, including their health and well-being, as they are psychologically internalised as part of self. Social identity approaches suggest that groups provide individuals with belonging, a sense of purpose, control and efficacy in life (Haslam et al., 2009). In this way group memberships can make individuals feel healthier and stronger, having a positive impact on health. However, sometimes group memberships, such as stigmatised groups or groups that do not provide social support, can negatively affect individuals (Jetten et al., 2017).

When a change of social identity occurs, the individual needs to redefine the meaning of that identity and reformulate the relationship between the self and others in the group. A facilitator of this process can be the availability of other identities that may take the place of the old identity (Jolanda, Jetten, O'brien, & Trindall, 2002). Also, social resources are not a stable variable across the transition period, as they can be affected or changed during the transition, thus, the important social resources are the ones that remain or become available after the transition (Iyer, Jetten, & Tsivrikos, 2008; Praharso, Tear, &

Cruwys, 2017). To conclude, the way individuals perceive their transition (e.g., as stressful or not), their ability to manage it, along with the lack or not of social support can facilitate or have a dramatic negative impact on well-being, mental health and overall life satisfaction (Haslam et al., 2009).

a) Schlossberg's Transition Theory

A transition can occur when life events result in change and affect various aspects of an individual's life and their societal roles, which can be disabling for many. More specifically, Schlossberg (1981) defined transition as "*an event or non-event which results in a change in assumptions about oneself and the world and thus requires a corresponding change in one's behaviour and relationships*" (p. 5). Events are defined as those transitions that an individual counted on to happen and did occur and non-events are the transitions a person counted on to occur but did not happen as hoped. Types of transitions also include 'anticipated' and 'unanticipated' transitions: anticipated transitions are those that occur predictably in someone's life, whereas unanticipated are not predictable or scheduled. Context of transition refers to the relationship the individual has with the transition (i.e., personal, interpersonal, or community) and the setting where the transition occurs. Impact would be assessed by understanding how much an individual's life has been altered. According to Anderson et al., (2012), transition is a process that takes place over time rather than at one point in time. The framework of the transition theory is focused on the concepts of 'moving in, moving out, moving through'. When moving into a new situation, individuals must become familiar

with the new environment, roles, relationships and routines. It is pointed out by the authors that institutions or organisations which individuals were or will be part of, need to implement orientation programming to help individuals prepare and know what to expect. The moving through period is when individuals start to familiarise themselves with the new situations and try to balance their activities with other parts of their lives. Moving out period is when the transition becomes integrated, stability is re-established, and individuals start to look forward to the future. This is the Adaptation to transition is the process during which the individual moves from being preoccupied with the transition to integrating the transition into their lives (Schlossberg, 2008).

The individual's perception of the transition plays a key role in understanding how they can be affected by their changing life events as much as the type, context and impact of the transition itself (Barclay, 2017; Schlossberg, 1981). An individual's ability to cope with transition is influenced by four major sets of factors which are called the 4 S's: Situation, Self, Support, and Strategies (Schlossberg, 1981, 2011).

Situation

This refers to the person's situation at the time of transition. When a transition occurs, the individual develops a perception of what is happening and the way they assess the situation can significantly affect how they will manage this transition. The individual considers the following factors when assessing their situation: what triggered the transition, the timing, the aspects of the transition they can or cannot control, if there is a role change involved, the

duration of the transition, sources of stress and if the transition is viewed as positive or negative.

Self

This refers to the individual's inner strength for coping with the situation. Personal and demographic characteristics, such as socioeconomic status, age, gender, stage of life or state of health, affect how an individual views life and how well they will cope with the transition. Psychological resources, such as optimism, resilience, ability to deal with ambiguity, and the individual's perception of what is happening, also play a significant role on how successfully they will manage their transition. Transitions take time, and people's reactions change; different individuals react differently to the same type of transition or the same individual may react differently at different times in their life.

Support

The support available at the time of transition is critical to one's sense of well-being. It is well-documented that social support, including intimate relationships, family, friends, co-workers, and communities, is the key facilitator of handling stressful and challenging situations.

Strategies

There is no right or wrong coping strategy, rather the individual who flexibly uses lots of strategies will be better able to cope with their transition. There are four coping modes recommended are: direct action, inhibition of action, information seeking and intrapsychic behaviour. However, if one's situation is

challenging and lacks social supports, it may cause delay to the change until supports are established in the new community and the situation improves.

b) Social Identity Theory

Social identity theory (SIT) was developed by Henri Tajfel between 1971 and 1981 with the vital contribution of John Turner (Tajfel & Turner, 1979) as a way to explain intergroup behaviours. SIT remains the key framework for discussing identity issues. Social identity is an individual's sense of who they are based on their group memberships, such as social class or family, which become an important source of pride and self-esteem. Individuals adopt the identity and behaviours of the groups they belong to, as groups provide them with a sense of belonging in the social world and in turn their self-esteem is linked with these groups. Purely interpersonal or purely intergroup behaviours are unlikely to exist in realistic social situations and that is why SIT proposes that social behaviour is a combination of both interpersonal and intergroup behaviours (Haslam, Reicher, & Reynolds, 2012). Individuals consider the group to which they belong (in-group) as being different from other groups (out-groups) and members of the in-group as being more similar than they are. Individuals perceive themselves to share group membership in a given context and actively strive to coordinate their behaviour in relation to activities that are relevant to that identity. Individuals enhance the status of the in-group or holding prejudice views against the out-group, to increase their self-image and self-esteem. If the in-group is threatened in some way, the individuals will act to preserve the identity of the group and increase their own self-esteem.

c) Stress Process Model

The Stress Process Model (Pearlin et al., 1982) can offer additional insights in the impact of life transitions on the individual. It focuses on how desirable or undesirable transitional events, chronic stressors, self-concepts, coping, and social support are linked to form a process of stress. Stressors can diminish self-concepts and threaten personal identities, leaving individuals vulnerable to experiencing symptoms of stress. Individuals can effectively cope with their transition when they manage to integrate their new social identity with the old (Amiot et al., 2007). The individual's personal, socioeconomic and social resources play a significant role in buffering the impact of transition on their well-being (Elder, Johnson, & Crosnoe, 2007; Gecas, 2007). Personal resources which can facilitate transitions include individual or social-psychological characteristics, such as resilience, self-efficacy, self-esteem and coping strategies. For example, individuals who employee active coping or problem-solving strategies are able to better manage challenges that those who respond passively or ignore the problem. Tangible and intangible support can also contribute as a facilitator or barrier for dealing with stressful life transitions. Good economic resources and perceived and actual social support from family or community can buffer the negative impact of transition or undesirable life events (Mortimer & Shanahan, 2003)

1.4.2 Military Environment

1.4.2.1 Military Transition

Military transition can be defined as the period of reintegration from military into civilian life and describes the process of change that military personnel undertakes when their military career finishes. There are theories/frameworks aiming to inform this complex process, yet no single theory/framework is widely accepted (Pedlar et al., 2019). They all have common features, including identity disruption, finding a new sense of purpose, employment and financial transition, sources access and importance of support (social/family support, health care/rehabilitation services).

US: Military Transition Theory

In the US, Castro and colleagues conducted research and developed a theoretical framework, which helps conceptualise the process of transition from military to civilian (Castro & Kintzle, 2016; Castro, Kintzle, & Hassan, 2014). Castro's Military transition Model is defined by three interacting and overlapping components (Figure 1):

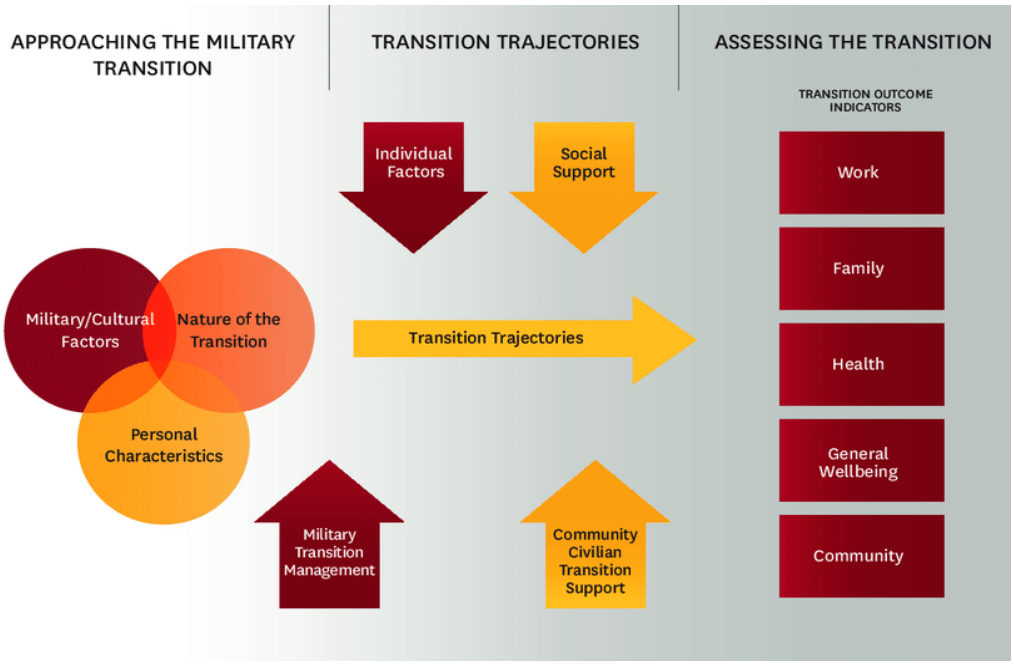


Figure 1 Military Transition Theory (Castro, Kintzle, Hassan, 2014)

i. Approaching the Military Transition, which includes military/cultural factors, personal characteristics and the nature of the transition.

ii. Transition Trajectories/Managing the Transition, which refers to factors impacting the individual progression from service member to civilian. For example, individuals' coping styles, attitudes and beliefs and social support, such as family, friends, community and society, may have an impact on transition.

iii. Assessing the Transition, which describes outcomes associated with transition that are measured through the categories of work, family, health, general well-being and community.

UK: Bourdieu's concepts

In the UK, Cooper and colleagues employ the theoretical framework of Pierre Bourdieu to examine the notion of 'transition' from military to civilian life for UK military personnel. They use Bourdieu's concepts of habitus, capital, and field in order to indicate the key differences between military and civilian life. They also use social theory to describe the military cultural setting and how this may influence the post-transition course of veterans' lives. Since military and civilian cultural settings are equal on neither practical nor emotional levels, when service personnel move into civilian life, there can be positive and negative transition outcomes. Applying Bourdieu's framework provides a conceptual underpinning to understand and better explained the movement between the military and the civilian fields and the difficulties that can occur when negotiating new roles within these social fields (Cooper, Caddick, Godier, Cooper, & Fossey, 2018; Cooper et al., 2017). They developed a model (MoTiVe) to create new practical understandings of transition underpinned by sociological theory, yet this model has not been implemented in empirical research. The theoretical model suggests that there is a powerful interaction between individual, accepted cultural behaviour and societal views in negotiating the military to civilian transition process.

1.4.2.2 Military Identity

The Canadian Institute for Military and Veteran Health, published a report aiming to understand the concept of 'veteran identity' and how this relates to well-being in military-civilian transition or later life (Thompson et al., 2017).

The report sheds a light and addresses many issues regarding veterans' identities and demonstrates practical real-world applications of knowledge about identities in supporting adaptation to civilian life and policy. The report recognises the life course evolution of veterans' identity: (i) the formation of the pre-service civilian identity (e.g., childhood), (ii) which changes to military identity when the individual identifies themselves as part of the military after enrolment, (iii) which then changes again to post-service veteran identity after leaning the military. Most of the service personnel join the military at a very young age, thus they have not fully developed an adult civilian identity and a clear understanding of the civilian values and beliefs. Indeed, it is unclear how the development of an adult identity during military service affects adaptation to civilian life at release from service.

Developing a military identity during recruit training is a formalised, intense process and the same applies to when service members shape post-military identities when leaving the military. Most military personnel resolve identity issues relatively easily, while others have significant challenges in constructing an effective post-military identity (Blackburn, 2016). Leaving or being rejected from a preferred social group disrupts an individual's identity and in turn causes distress or cuts the individual off from material and psychological resources that allow them to live well (Thompson et al., 2017). Transition and adjustment to civilian life can be particularly challenging for those who have deeply invested military identities, experienced involuntarily release from service, do not have social resources or experience in civilian society and workplaces, they have developed mental health problems or suffered physical

injuries while serving (Robinson et al., 2017). These situations can lead to feelings of identity loss and betrayal, as the individuals, apart from coping with identity change (from military to civilian), they have the added difficulty of learning to live with ill health (Coll & Weiss, 2013). Military identity also fulfils the need for sense of purpose and having a meaningful role in terms of employment, which provides important feedback regarding one's capacities, skills and values. Most service leavers must seek civilian employment rather than retiring and many of those successfully adjust to civilian jobs or education. However, there are service leavers who face numerous challenges in finding employment, either due to health-related problems or mismatch between military occupation and civilian employer requirements or stereotypes held by civilian employers (Castro & Kintzle, 2016).

Interventions and resettlement programmes should address the unique needs and problems veterans themselves identify as major barriers, yet not many studies focus on veterans' perspectives on their post-deployment reintegration. Orazem et al., (2017) explored the perceptions of identity adjustment from military to civilian life, by conducting a thematic analysis of text written by 100 Afghanistan and Iraq war US veterans who have been asked to describe their reintegration difficulties as part of a randomised controlled trial. Results indicated interrelated areas of identity adjustment difficulty; participants had difficulties to find a sense of purpose, missing the military culture and structured lifestyle, feeling that they do not belong in civilian society. They were holding negative views of civilian society, feeling left behind compared to civilian counterparts due to military service. Similar qualitative

studies (Demers, 2011; Smith & True, 2014) also indicate that veterans felt misunderstood and out of place in civilian society, caught between military and civilian culture, which led to a crisis of identity. Identity adjustment is a central aspect of veterans' reintegration into civilian society yet remains understudied.

1.4.2.3 Men & Masculinity

The sociologist Raewyn Connell's theory of masculinity is one of the most influential theories in the field of men and masculinities, not only on the field of gender studies but also across a wide range of other disciplines, such as health psychology (Connell, 1994, 1995, 2005; Wedgwood, 2009). The concept of 'hegemonic masculinity' is particularly relevant here. It refers to the hierarchical dynamics not only between men and women, but also between men themselves, including the elements that justify men's dominant position within a given society/community and time. Even though this concept has been criticised or reformulated in a number of ways, it is still a starting point for thinking about the theorisation of masculinity and encapsulating (Murphy, 2019; Wedgwood, 2009) the image of manhood, e.g., 'act like a man', 'men do not cry'.

In the field of men's health many conceptual and theoretical assumptions have been made around how masculinities and differing ways of being a man can influence men's varied health and social practices. Many of these assumptions have also included exchanges on how masculinities interact with other identity issues, such as socioeconomic background, disability, ethnicity, sexuality, or

age (Robertson & Kilvington-Dowd, 2019). Research in masculinity and male identity indicates that men have to be competitive, powerful, successful in their professional and personal life, able to strive for dominance and not demonstrate emotions, vulnerability or weakness, in order to be considered adequately masculine be others (Barker & Ricardo, 2005; Beaglaoich et al., 2014; Moller-Leimkohler, 2003; Searle et al., 2019). In Western cultures there is still the dominant negative interpretation of men displaying non-masculine behaviour, which can discourage them from disclosing emotional distress or displaying behaviours which are considered feminine (Moller-Leimkohler, 2003; Wilkinson, 2004). 'Traditional masculinity' is a key risk factor for male vulnerability as it can have a negative impact on health behaviour by promoting unconstructive coping strategies and emotional inexpressiveness (Connell, 1995; Murphy, 2019). Indeed, research in both male civilian (Courtenay, 2000, 2004; Murphy, 2019; Robertson & Kilvington-Dowd, 2019) and military populations as discussed in Chapter 1 (Barrett, 1996; Lee, 2016; Reit, 2017) indicates that men are reluctant to seek help from healthcare professionals in fear of being considered weak or undermining their sense of masculinity. These unhealthy attitudes can increase men's vulnerability and lead to unhealthy outcomes, such as feelings of shame and inadequacy, violent behaviour, suicidal thoughts or attempts, depression and alcohol misuse (Courtenay, 2004; Lynch et al., 2018; Searle et al., 2019; Sloan et al., 2015). Nevertheless, aspects of masculinity have been shown to be related to health-promoting behaviours, such as working out or avoiding alcohol (Sloan et al., 2015; Sloan, Gough, & Conner, 2010; Smith, 2013).

Disability, Mental Health & Masculinity

Permanent physical injuries or mental health problems can lead to social devaluation and low self-regard, causing serious problems to individuals, who may be unable to accomplish daily activities or fully participate in family, occupation and social roles (Lindinger-Sternart, 2014; Luborsky, 1994; Wong et al., 2017). Masculinity refers to power and autonomy, while any form of disability or mental health problem is associated with being weak, helpless or dependent (Manderson & Peake, 2005; Shakespeare et al., 1996). One of the cultural consequences of being mentally or physically traumatised is that an individual's identity as a complete person comes into question and degrades their position as a full person (Easton, 2014; Luborsky, 1994; Vogel & Heath, 2016). Individuals who suffer a permanent physical injury after they develop an embodied identity as non-disabled individuals, can become disconnected from their impaired bodies (Seymour, 1998). The traditional idea of the male body is constructed around the notion of control and strength and when it is transformed by a physical injury, it can be feminised and in-validated (Rapala & Manderson, 2005). It is also well-documented in research that men seek support for their mental health less than women, something that leads to an increased physical and psychological toll on them (Oliffe & Han, 2014; Vogel & Heath, 2016; Wong et al., 2017). Research in military and civilian male population indicates that men's adherence to socialised masculine norms, can be associated with negative attitudes and lower intentions to seek professional support. For example, attend therapy sessions may be perceived as being weak, as it requires asking for help and engaging in emotional vulnerability

(Hammer & Vogel, 2010; Heath et al., 2017; Kulesza et al., 2015). Indeed, when gendered performance breaks down, masculinity becomes vulnerable (Connell, 1995), i.e., 'real' men who lost their masculinity due to an amputation, injury or mental health problem. Research on intersection of gender and disability indicates that there is a conceptual and embodied dilemma for disabled men, which is experienced at a personal level (Hahn, 1988; Shuttleworth et al., 2012). The association between physical impairments and negative body image points out the link to a damaged identity and self-esteem (Luborsky, 1994; Rapala & Manderson, 2005). Similarly, individuals who suffer from mental health problems need to overcome the loss of identity, valued social roles, and purpose in life. Rebuilding a sense of self and a social identity is a core part of recovery as individuals have to grow and develop beyond the limits imposed by their cognitive and emotional difficulties and rebuild a meaningful life (Carless & Douglas, 2008; Davidson & Roe, 2007; Morgan et al., 2013).

The question here is how physically and mentally traumatised men can successfully negotiate the intersection of normative expectations of masculinity and trauma. Developing a better understanding of how men can recover or reconstruct their masculinity, can be achieved through alternative routes, such as physical activity. Sport is a culturally constructed phenomenon in western society, linked to physical strength and ability (Easton, 2014; Manderson & Peake, 2005; Sandahl & Auslander, 2005). As Connell (1995) reported "*sport has come to be the leading definer of masculinity in mass culture"* (p.54), as athletes embody the physical ideal of health. Also, physical

activity can play a significant role in the management of mild-to-moderate mental health problems, such as depression and anxiety (Paluska & Schwenk, 2000), which are usually the most common issues among ex-military personnel who suffer from a mental health problem (Pietrzak, Pullman, Cotea, & Nasveld, 2012; Vogt, 2011). Traumatised men, and especially male military veterans for whom masculinity is deeply embedded in their conscience and identity shaped in the military, may desire to reinvent themselves through sport. Current research shows that physical activity and sport are considered meaningful activities and contribute to developing self and identity, being involved in meaningful activities, being supported by others, and renewing hope and commitment (Carless & Douglas, 2008; Brett Smith & Sparkes, 2012). Physical activity can help them recover their status, masculinity and rebuilt a positive sense of self and identity (Carless & Douglas, 2008; Paluska & Schwenk, 2000; Robertson et al., 2015).

1.4.3 Psychology of Trauma

1.4.3.1 Trauma

Traumatic events are usually unpredictable and uncontrollable. The two factors that make an event traumatic is the threat of death or serious injury to self or to another person and a strong feeling of fear and helplessness. Trauma (one-time, multiple, repetitive) affects everyone differently, including a variety of immediate or long-term reactions (SAMHSA, 2014; Williams & Banyard, 1999). Exposure to traumatic events may shatter individuals' sense of security and leave them feeling vulnerable and agitated. More specifically, it can be

associated with a wide variety of reactions, including psychological (posttraumatic or acute stress, dissociation, depression, anxiety), physical (fatigue), cognitive (guilt, low self-esteem), behavioural (relationship problems, substance misuse, suicidality) (Williams & Banyard, 1999). Individuals vary in their responses to trauma. The way each individual experiences the traumatic event, the meaning they ascribe to it and the actions they take result from their personal characteristics, past experiences, present context and physiological state (Butler et al., 2007). The normal course of recovery begins at the time of the event with very strong reactions and moves forward in time with gradual healing and recovery. Traumatic experiences may overpower coping resources at the time, with the individuals trying to make sense of the traumatic event, feeling vulnerable and hopeless (Resick, 2001). Severe, prolonged reactions can be disabling, and can affect individuals' personal lives. Traumatisation occurs when individuals' internal and external resources are inadequate and so they cannot cope with their traumatic experience, they are unable to handle the intense feelings, undertake responsibilities or identify potential triggers, have flashbacks, or cannot share their feelings with others (Resick, 2001).

Traumatic experiences can affect and alter individuals' cognitions by challenging their views for the world and the core life assumptions that help individual live a healthy daily life (e.g., "People cannot be trusted"), the way they view themselves (e.g., "I am incompetent") and the way they vision their future (e.g., "What is the point?") (SAMHSA, 2014). Subsequently, this set of cognitions can have a significant impact on individual's belief in their ability to

use internal resources and external support effectively. An integral part of experiencing and coping with trauma is for individuals to feel different from others. The type of trauma can affect individuals differently. Life events can be interpreted positively or negatively, with a sense of optimism or pessimism in judgements, showing the central role of individuals' evaluation and interpretation of the world on the way they choose cope, successfully or not, with life challenges. Survivors use comparison processes to evaluate their situations and coping success, in their effort to address concerns about self and benevolence (Rose, 2005). Traumatic experiences that generate shame, such as war and combat experiences, can lead survivors who shared traumatic experiences to develop feelings of self-blame (e.g., "*Why me/us?*") and if they survived while others have not, feelings of survivor-guilt (e.g., "*Why have I lived while others have not?")* (Janoff-Bulman, 1992). When survivors consider their experiences incomprehensible and unique, they are more likely not to seek support, but if they do they prefer individuals who have experienced a similar trauma (SAMHSA, 2014).

1.4.3.2 Military Trauma

During WWI, psychiatrists observed that soldiers returned with "shell shock" (Myers, 1915). Psychological first aid was first developed to help the soldiers recover and return to the front as soon as possible. During WWII, psychiatrists reintroduced hypnosis as a treatment for trauma, and the US Army instituted the use of "group stress debriefing". After WWII, studies focused on the outcomes of prolonged traumatisation on concentration camp survivors

coincided with observations of combat stress. Theoretical contributions to the understanding of the long-term impact of combat trauma also made while treating Vietnam veterans and as a result psychological trauma and PTSD were included in the *DSM-III* (APA, 1980; Ringel & Brandell, 2012). Little research into the mental health of serving members or veterans of the UK Armed Forces was undertaken between 1945 and 1995. However, the emergence of the so called "Gulf War Syndrome" amongst personnel who took part in the 1991 Gulf War led to changes and the commissioning of population-based research into the health and well-being of UK Gulf War veterans (Hunt et al., 2014).

Trauma remains an ongoing concern among military personnel. As explained in section 1.2.1.i '*Mental Health'*, military personnel are at higher risk of being exposed to a number of potentially traumatic events and stressors, compared to civilians, including extended tours of deployment, life threatening combat situations, higher risk of injury, military sexual trauma, witnessing violence and death, while being far from their support networks (e.g., family/friends) (Bowling & Sherman, 2008; National Center for PTSD, 2019). Combat exposure and all the battlefield stressors military personnel can be exposed to, may increase the chances of developing PTSD or other mental health problems. Nevertheless, this does not automatically mean that all military personnel with similar experiences will develop mental health problems. It is also important to note again here, that the majority of military personnel who develop mental health problems do not necessarily meet the full criteria for PTSD, rather they report trauma symptoms or CMD. Similarly to civilian trauma theory, certain beliefs about traumatic events can become a barrier to care (e.g., self-stigma).

Due to stigma and the military's masculine image it can be hard to make sense of the experience particularly for military personnel, who are used to self-reliance and controlling emotions. These strategies may work in the short-term but can harm individuals in the long-term (Kendall-Tackett, 2019). Moral injury-based traumas can also greatly affect service members who served in combat and had to kill, witness death, or failed to prevent immoral acts or the death of comrade (Norman & Maguen, 2019). Veterans who suffered trauma but did not manage to cope effectively may face issues in personal life with their family, relationships or friendships, as well as in their professional life, which in turn will have a negative impact on their health, well-being and identity formation (Williams & Banyard, 1999).

1.4.4 Narrative Approaches

We live in a storied world replete with narratives and we interpret the actions of others and ourselves through the stories we exchange. Humans seek meaning and purpose in life and stories are the tool to create meaning from experiences (Bruner, 1990). Narratives are part of our daily lives in terms of communicating with others and making sense of the world around us (Hutto, 2007). Individuals construct and share stories about themselves detailing particular events or periods in their lives and what those experiences mean to them (McAdams & McLean, 2013; Murray, 2003, 2008). There is not a clear definition of narrative, yet there is an agreement that narrative forms are not just a simple chronological description of events, but rather a way to explain human emotions, motivations and values, make meaning and construct an identity (Fivush et al., 2017). Narrative and storytelling can be a helpful means

of re-organising the chaotic nature of core life events (e.g., traumatic experience, diagnosis of an illness), which may challenge one's beliefs about themselves and the world (Burnell et al., 2009). The narrative can lead to an understanding of the high and low points in life within the context of someone's complete life story, help them make sense of their experiences and make it more likely that they will 'grow' as individuals through this process (Pennebaker & Seagal, 1999; Catherine Kohler Riessman, 2008).

The concept of narrative and its associated research techniques have been applied in a wide variety of fields, such as individuals with severe mental health illness (Allé et al., 2015), LGBT community (Hammack & Cohler, 2011), forensic populations (Ioannou et al., 2017), athletes (Carless & Douglas, 2013) and the field of psychotherapy (Capella et al., 2016) and in a medical context (narrative medicine) (Charon et al., 2017).

1.4.4.1 Narrative Meaning-Making

There are different theoretical perspectives of what narrative meaning-making is (Adler et al., 2016; Habermas & Kober, 2014; McAdams & McLean, 2013), yet there are manty similarities across cognitive, developmental and personality literatures. It is difficult to make clear distinctions among forms of meaning-making when assessing it, as many of those overlap. The main four broad forms of narrative meaning-making are (Fivush et al., 2017):

(i) Coherence

Coherence is the ability to create order in a narrative to achieve chronological coherence (i.e., narrate events in a clear way), context coherence (i.e., describe

time and space or cause/effect relationships of an event) and thematic coherence (i.e., make reflective evaluation and elaborate on connections among events across the narrative) (Reese et al., 2011). Developing a sense of identity is linked with the narrator's ability to make a coherent meaning-making; to be able to make explicit connections among events, life experiences and self-concept in their life narrative.

(ii) Subjective Perspective

A narrator's ability to connect the external world to their internal consciousness refers to the basic ability to refer to past experiences with limited awareness of how subjective perspective may change over time. Nevertheless, acknowledging the differences among narrators' thoughts and feelings about a similar events in their lives from the time of the event to the present can indicate the development of a sense of consistent consciousness over time (Fivush, 2012).

(iii) Integrative Meaning

Integrative meaning reflects on how subjective perspective can evolve over time. When the narrator recognises the changes in the emotions and interpretations of life events since they occurred, it is an indication of personal growth, redemption and integrative meaning through the narration of perspectival change (Pals, 2006). This allow individuals to link subjective consciousness with life experiences and self and develop a larger sense of purpose.

(iv) Motivational Themes

Motivational themes connect narrative identity to personality, indicating narrator's motivations, values and approaches to life (McAdams & McLean, 2013), providing continuity of identity through consistency of those factors across different events (McAdams, 1990).

Apart from the purpose of the life stories or storytelling patterns, the role of the listener influences the way stories are told. For example, listener attentiveness resulted to more coherent and engaging stories (Bavelas et al., 2000). Audience is vital to the creation of self as it helps to develop empathy between the narrator and listeners, which can lead to more intimate sharing and deepen the connection of the narrator's own identity.

1.4.4.2 Narratives & Trauma

In the narrative approach, human development is a combination of the construction of a personal narrative across the life course that provides meaning and integrative function to the individual (Hammack et al., 2008). The narrative is a way of organising episodes and actions and brings together facts and fiction, time and place (Hutto, 2007). Through the narration of the stories, individuals can explain the events they have experienced, the decisions they have made, better understand and reveal themselves to others. Through this the life course achieves its coherence, its continuity in social, cultural, and historical time. The narratives express the identity of the individual as an inner story of the self, which includes the reconstructed past, perceived present, and anticipated future (McAdams, 1995). To fully understand a person, someone

has to know more than just their traits or personal concerns; they must know about his or her identity, something that can be achieved through encountering the life story narrative that they have constructed. In this way, identity is understood as a life story, representing an individual's personality beyond traits and personal concerns (Hammack et al., 2008; McAdams, 1995). Traumatic events can disrupt life stories (Hunt, 2010) and lead to traumatic dissociation, including feelings of depersonalisation, derealisation, detachment from others and reduced responsiveness to surroundings. Dissociation does not allow the individual to process the trauma and can lead to poor integration of trauma in memory, which then leads to intrusive phenomena, such as flashbacks and ultimately PTSD or depression (Breh & Seidler, 2007). Traumatic experiences can affect the plot line of the life story and the narrative becomes disorganised, fragmented and incoherent, that is why narratives can be a significant aspect of trauma recovery (Norman, 2000). One of the findings about narrative in clinical psychology is that it enables individuals to develop coherent stories about difficult or threatening experiences. Whilst traumatic experiences tend to create a fragmented narrative, the ability to re-organise and re-build it, can facilitate resolution (Crossley, 2000b). The narrative can lead to an understanding of the event within the context of the complete life story and help the individual to make sense of or find a meaning in their traumatic experiences (Hutto, 2007).

(i) Narrative Approaches to Therapy

A narrative is an organised interpretation of sequence events, mental states and happenings (Murray, 2008a). A story or narrative account of an incident has three components: a beginning, middle, and an end. Based on narrative theory, narratives lie at the heart of being human and that is because we live in a storied world. Our lives are the combination of creating and exchanging narratives. The main purpose of narrative approach is not to establish a universal truth (White & Epston, 1990) but rather to take into account the stories, feelings, thoughts and meaning-making for each person.

When individuals suffer from mental illness, such as depression or PTSD as a result of a traumatic experience, incoherence can prevail due to individuals' inability to bring sense to this obscure experience and construct a reality (Murray, 2008). Through narratives individuals can rebuild the shattered sense of identity replacing it with a new sense of who they are (Crossley, 2000a). Narrative therapy is an approach to psychological treatment which places the individual as the lead expert in their lives and facilitates in helping them to use pre-existing skills to reduce the impact of trauma or problems in their lives. The therapy is also known as 're-authoring' or 're-storying' and it was developed by Michael White and David Epston (Epston & White, 1992). Every story consists of events that took place, which are somehow linked in a sequence and the way people understand stories is influenced by the environment, culture, and social context in which they function. During therapy, the therapist engages the client to look at the way in which they have constructed

the meanings of their stories and to consider re-interpretations or the construction of alternative meanings to their stories.

(ii) Narrative Exposure Therapy

A more recent method of psychological treatment, which uses narrative to achieve therapeutic effects and trauma reduction is Narrative Exposure Therapy (NET) (Schauer et al., 2011). NET is a treatment for trauma disorders, particularly complex and multiple trauma. Initially, it was developed based on testimony therapy and cognitive behavioural exposure to treat PTSD symptoms resulting from violence or multiple or continuous trauma. Initially, it has been devised specifically for the survivors of organised violence and it being tested with asylum seekers and refugees in high-income countries. NET is a manualised, short-term treatment (four to ten sessions) and it can be provided in small groups or individually. The core intention of NET is the healing of the individual and reconciliation from violence/traumatic experience. It allows individuals to undergo emotional exposure and process painful memories in a safe environment and facilitates in restructuring their autobiographical memories into a coherent narrative structure. This leads to the production of a written document/narrative, which is given to the client to read, as part of the therapeutic process. There have been a number of studies which have documented the effectiveness of NET in reducing symptoms of PTSD in individuals that have been affected by conflict (e.g., Ertl et al., 2008; Jacob et al., 2014; Neuner et al., 2008; Schaal et al., 2009). Emerging evidence indicated that NET can be an effective treatment for traumatised individuals

and results from treatment trials demonstrate the power of NET in reducing PTSD symptoms in adults (Lely et al., 2019; Robjant & Fazel, 2010). NET has been considered qualitatively comparable to those evidence-based trauma therapies, such as trauma-focused CBT or EMDR and it is included in the suggested interventions for PTSD treatment for adults in the UK (NICE, 2018) and the US (APA, 2017).

1.4.4.3 Narrative approaches in Military Research

Trauma spectrum disorders are still common in military personnel who have fought in past (e.g. Vietnam) and recent armed conflicts (e.g. Iraq/Afghanistan) (Seal et al., 2007), yet treatment response to trauma-focused therapy has often been poor for war veterans.

NET for forensic offender rehabilitation (FORNET) is used as an intervention to help traumatised offenders and veterans, aiming to reduce symptoms of traumatic stress and control readiness for aggressive behaviour (Hecker et al., 2015). The existing evidence of the randomized controlled clinical trials for FORNET suggests that addressing violent behaviour by means of NET is a promising approach to treat traumatised veterans and violent offenders and to support them to regulate their desire for aggressively acting out.

Caddick et al., (2015) conducted a research on UK combat veterans, who were all members of the same charity, using a narrative approach. The aim was to investigate how veterans experience their PTSD peer relationships and how these interactions may benefit veterans' well-being overall. Dialogical narrative approach can be a way to explore interactions between peer

relationships and well-being (Frank, 2012, 2010). This approach understands people as "*inherently relational rather than bounded individuals"* and storytelling *"as part of a dialogue between two or more voices*" (Caddick et al., 2015). Collective stories are an emotional bond between individuals who have shared similar traumatic experiences, allowing them to overcome some of the alienation and isolation they may experience in their everyday life. The results suggest that storytelling can help veterans build stronger relationships with the ones who share similar experiences and align their personal identity with that of the group. Moreover, narrative approach had a therapeutic effect (different from clinical model approaches) on veterans' lives in terms of a possible healing effect on the way they cope with their PTSD, affirming the value of peer relationships.

Narrative approaches and storytelling may enable traumatised veterans to overcome widely reported barriers to care, such as stigma, normalise their suffering and start seeking support for their health and well-being (Walker, 2010). A combination of narrative approaches and peer relationship interactions could be recognised and used in PTSD treatment process (Caddick et al., 2015; Hoge, 2011). Narrative processes and social connections through peer-to-peer programs could help clinicians and researchers to better understand and communicate with veterans that validate their experiences as warriors. For example, by developing a safe environment where veterans can interact with each other, share their stories and bond with other veterans could be more productive than focusing only on treating veterans as individuals.

1.5 Thesis Objectives

In order to actively improve the transition process from military to civilian life a deeper understanding is necessary. Despite the numerous studies on military and ex-military personnel, which cover all aspects of transition (employment, financial support, housing, mental and physical health issues), and the continuous efforts to actively support the veteran community and facilitate the transition process, major barriers remain. The main objective of this PhD is to develop a more sophisticated and holistic understanding of British male veterans' perspectives regarding the practical and emotional challenges faced during transition to civilian life, based on empirical research (UK-based) and theory. Different data collection (i.e., semi-structured and narrative interviews) and data analysis (i.e., thematic analysis and different narrative analytical frameworks) procedures were employed to allow for an in-depth understanding of veterans' subjective experiences, unique challenges and the ways they construct their own reality and sense of self during their journey to transitioning from civilian to military life and from military back to civilian life.

(i) Holistic Model of Military Transition

Drawing on veterans' lived experiences will allow for the development of a 'Holistic Model of Military Transition' (HMoMT) outlining the key stages through which the individual may travel on their journey to transitioning from civilian to military life and from military back to civilian life. At the same time, identify the factors that may facilitate the transition process, but also the underlying potential barriers that still hinder this process despite the

numerous improvements of services. As explained in section 1.4.2.1 *'Military Transition'*, Castro's model of military to civilian transition has been developed through empirical research in the US, yet it is internationally recognised. However, it focuses only on the second part of transition (i.e., from military to civilian life) and potentially missing valuable parts of the individuals' lives and the ways they have managed their first transition from civilian to military life. In the UK, only Cooper and colleagues have developed a theoretical framework to better explain military transition but based only on theory and not empirical research. The theories of transition (section 1.4.1 *'Self, Social Identity & Life Transitions'*) and particularly Schlossberg's Transition Theory[3] along with the data analysis form the chapters that follow will contribute to the development of a more holistic model of military transition based on empirical research in the UK. This will be discussed in Chapter 7 'General Discussion'. To the best of the researcher's knowledge, there is no other Model of Military Transition, which is based on theory and empirical research conducted in the UK.

(ii) Independent Studies

This PhD includes three independent studies, which investigate two alternative interventions (i.e., Competitive Motorsport and Life Narratives/Storytelling)

[3] Schlossberg's Transition Theory has been used to better understand student veterans who try to reintroduce themselves to academic work in the US (e.g., Ackerman, DiRamio, & Mitchell, 2009; Griffin & Gilbert, 2015) and not as a theoretical framework to develop a model of military transition based on research with UK military male veterans.

beyond conventional therapies, such as counselling or CBT, and an under researched area, which is the impact of transition on families, focusing on female spouses/partners. Each study has specific aims.

The aim of the Life Narratives/Storytelling study is to broaden and improve the theoretical understanding and the links between life narratives, traumatic experiences, transition process and veterans' perceptions and underlying unique needs. More specifically, to (i) pilot a new interview technique and identify its possible positive effects on mentally traumatised military veterans and (ii) explore in-depth how the pre-military & military traumatic experiences may affect veterans' identity and hinder or facilitate their transition to civilian life through the lens of Narrative Identity.

The aim of the Competitive Motorsport study is to explore and identify the benefits of competitive motorsport as an alternative intervention and generate recommendations for its inclusion into the existing therapies or activities for veterans. The promotion of new approaches and novel services will facilitate a smoother transition into civilian society and an improved quality of life, not only for veterans but their families as well. More efficient use of healthcare resources will reduce NHS costs and significantly improve veterans' wellbeing. Healthier veterans, in turn, will become a valuable asset to society and contribute to the country's economy by finding and maintaining employment, paying taxes and stopping benefits.

Finally, the study with female spouses/partners aims to shed light on the very significant topic of social support in a personal and interpersonal level. This will

be achieved by exploring the impact of transition on veterans' female spouses/partners, identifying the unique challenges faced by the latter and the coping strategies used to overcome them, successfully or not (i.e., personal level) along with the overall effect on the relationship and the dynamics between the couple (i.e., interpersonal level).

1.5.1 Thesis Chapters

This is a brief summary of the thesis structure and chapters:

Chapter 2: *"Methodology"*

An overview of the methodological issues surrounding this PhD research studies is presented in this chapter.

Chapter 3: "*Life Transitions: From Civilian to Military & Military to Civilian Life*"

The chapter aims to build on previous research in order to develop a more sophisticated and holistic understanding of male veterans' subjective experiences during transition to civilian life and identify potential factors that hinder or facilitate their transition.

Chapter 4: *"Storytelling as an Intervention: The Narrative Life Interview (NLI)"*

This chapter aims to (i) pilot a new interview technique (Narrative Life Interview) and (ii) explore in-depth how the pre-military & military traumatic experiences may affect veterans' identity.

Chapter 5: *"Sport as an intervention for Physically Injured Military Veterans: The example of Competitive Motorsport"*

This chapter will focus solely on Competitive Motorsport (CM) as an alternative intervention, exploring the social and psychological impact on veterans' well-being.

Chapter 6: *"Family Reintegration - Experiences & Insights of British Military Veterans and their female Spouses/Partners"*

This chapter aims to explore the challenges veterans' female spouses/partners face during their husbands'/partners' transition, along with the overall effect on the relationship and the dynamics between the couple.

Chapter 7: *"General Discussion & Conclusions"*

General discussion and conclusions.

Chapter 2 - Methodology

2.1 General Introduction

An overview of the methodological issues surrounding this PhD research studies will be discussed in this chapter, including researcher's epistemological stance and information regarding the reasons behind selecting specific analytical methods across the studies conducted. The method (i.e., study design, participants, measures, procedure) for each study will be presented in the respective data chapters (Chapter 3 - 6).

2.1.1 Population

The studies focus on veterans and – in the final study – their female spouses/partners.

In total, twenty-seven British male veterans took part[4] in the Narrative Life Interview study and the Competitive Motorsport study. Participants were either physically traumatised (e.g., injured, amputees), psychologically traumatised (i.e., PTSD, depression, anxiety), or both. Physical trauma occurred either during combat or military training. Emotional and psychological trauma was recognised through self-assessment or diagnosed through professional assessment, during their military service or after leaving

[4] Another five male participants took part in the follow-up interviews for the CM study. These individuals were also British male veterans, former members of KartForce, who took part in a previous study (Hunt, 2014) with regard to their participation in karting.

the military. All participants faced (direct or indirect) challenges during their transition from military to civilian life, which were not always linked with their physical or emotional trauma.

Veterans' female spouses/partners experienced former's transition from military to civilian life, either the entire transition (still together) or part of it (divorced, separated, relationship occurred later). In total, nine female spouses/partners took part in this study. Participants were affected by this process on a (i) personal level, for example, some of them had to quit their job/career or move to a different location, but also on an (ii) interpersonal level, as this process challenged the relationship and the dynamics between the couple.

2.1.2 Recruitment

Participants were recruited using opportunity sampling, starting with the links the researcher had at:

(i) KartForce (www.kartforce.org), an organisation in the UK set up to help injured veterans race go-karts and cars competitively (i.e., all participants of the Competitive Motorsport study, fourteen in total, plus five individuals former members of KartForce).

(ii) VOS (Veterans Outreach Support - http://www.vosuk.org/), which provides drop-in meetings and counselling for former members of the British Armed Forces. This enabled access to ex-military population across the United Kingdom and the recruitment of a diverse sample (i.e., some of the participants of the Narrative Life Interview study, three in total).

The rest of the participants (ten in total) who took part in the Narrative Life Interview study and the female spouses/partners study (nine in total) were recruited using snowball sampling (i.e., friends or spouses/partners of the veterans who had already participated in the studies). Further details regarding recruitment for each study are explained in the method section of the respective chapters.

2.2 Epistemological Stance

2.2.1 Qualitative Inquiry

Qualitative inquiry is a very broad umbrella term, which includes a wide range of approaches and methods. It is often described as a naturalistic, interpretative approach, with the main focus on exploring phenomena 'from the interior' and taking research participants' perspectives and accounts as a starting point (Flick, 2009). Denzin & Lincoln (2011) argue that the reason that makes it more difficult to define qualitative research clearly is that it has no specific theory or paradigm that is distinctively its own. Qualitative research is often associated with specific kinds of methods (e.g., ethnography, interviews) and data (e.g., text or images rather than numbers). Yet, despite the diversity within qualitative research, what is highlighted is the volume, richness and complexity that can be achieved. Qualitative researchers study phenomena in their natural settings, attempting to achieve an in-depth and interpreted understanding of the social world of individuals in terms of the meanings the latter bring to them. Important to note here is the element that distinguishes qualitative research is often the fact that hypotheses are commonly generated from analysis of the data rather than stated at the outset (Silverman, 2011).

2.2.2 Conceptual Terms

Ontology & Epistemology

The issues of how the social world can be studied and understood as well as how knowledge can be generated, raise several philosophical questions. Qualitative researchers try to make sense of social reality and for that they engage in the practical activities of gathering and interpreting data to answer questions about the meaning of what their participants believe, think and do. To decide what kinds of knowledge are possible, qualitative researchers' practices have to be underpinned by epistemological stances that provide a philosophical grounding (Maxwell, 2011). These philosophical and theoretical positions embrace different perspectives of understanding human action, different ethical commitments, methodological and epistemological issues. Some of these philosophical questions relate to 'Ontology' and some to 'Epistemology' (Ormston et al., 2013). These will be briefly explained below as it is outside of the scope of this section to describe these positions in detail[5]. The *Interpretivist* approach is particularly relevant and thus adopted in this PhD. *Interpretivist* approach is based on naturalistic approach of data collection (e.g., interviews), where meanings emerge usually towards the end of the research process. In general *Interpretivist* approach is based on idealism

[5] For detailed information on key philosophical issues in qualitative research please read Ormston et al. (2013) or Guba & Lincoln (2005).

ontology (i.e., reality is perceived as intersubjective) and subjectivist epistemology (i.e., individuals cannot be separated from their knowledge).

Ontology is concerned with the nature of reality and what there is to know about the world. The focus is on questions regarding social reality and if it exists independently of human conceptions and interpretations or not. There are two main ontological positions: Realism and Idealism.

a) *Realism* supports the idea that an external reality (social reality) exists independent of our understanding and beliefs. Variants of realism include: naive realism, cautious realism, depth realism, subtle realism and materialism.
b) *Idealism* supports the idea that no external reality exists independent of our beliefs and understandings. Variants of idealism include:

   (i) contextual/collective idealism (i.e., the social world is made up of representations constructed and shared by individuals in particular contexts).

   (ii) relativism/radical idealism (i.e., there is no shared social reality, only a series of individual constructions). Relativist ontology perceives reality as intersubjective/finite, being based on understandings and meanings. In other words, reality is not distinguishable from the subjective experience of it (Guba & Lincoln, 2005).

Epistemology is concerned with ways of knowing and learning about the world and it is closely connected with ontological issues. The focus is on issues such

as what forms the basis of our knowledge and how we can learn about reality. There are three main epistemologies (Crotty, 1998):

a) *Objectivism*: In this epistemology meaningful reality exists as such, apart from the operation of consciousness. Values and understanding are considered objectified and the objective truth can be discovered.

b) *Constructivism*: In this epistemology the objectivist view is rejected as the meaningful reality is constructed by individuals (sometimes in a different way for the same phenomena) and cannot be discovered.

c) *Subjectivism*: In this epistemology the meaningful reality is always filtered through the lenses of the individual believer or those of the believer's community, taking into account the language, gender, social class or ethnicity. Subjectivism recognises knowledge as value laden but does not deny that an external reality exists. Observations are influenced by the observer and at the same time the observer is influenced by the observed (Denzin & Lincoln, 2005).

Paradigms

Paradigms are frameworks that are used by researchers to generate knowledge and refer to a system of ideas or world view about the nature of knowledge and existence. In order for researchers to ensure a strong research design, a paradigm that is congruent with their beliefs about the nature of reality should be chosen (Fossey, Harvey, McDermott, &

Davidson, 2002). There is a variety of paradigms yet there are three key theoretical perspectives that are considered the foundation of social research (Willis, 2007a): *Positivism*/*Post-positivism, Critical Theory* and *Interpretivism*.

a) *Positivism/Post-positivism:* It is conceptualised as having an objectivist epistemology and critical realist ontology. The main principle of *positivism* is that the world is external and that there is a single objective reality to any research phenomenon regardless of the researcher's perspectives or beliefs (Hudson & Ozanne, 1988), and it is highlighted that the researcher can remain independent. *Post-positivism* is a metatheoretical stance that critiques and amends positivism. Post-positivism accepts that even though truth exists, knowledge is fallible because it is shaped by contextual influences yet trusting that objective investigation will bring researchers closer to the truth (Clark, 1998). It also acknowledges that researchers' knowledge and values can influence the interpretation of the data.

b) *Critical Theory*: It is conceptualised as having a modified subjectivist epistemology and a historical ontology[6]. Critical theory examines

[6] A brand of philosophy, which takes up history to confront philosophical problems. The main principle of *Historical ontology* is the assumption that everything that exists comes into being

oppression and routes to challenging oppression, focusing on exploitation of parts of society and society's view of individuals as political or other objects (Bronner, 2011). The main principle is to look beyond the surface of social life, uncover the nature of power relationships in a culture and uncover the constraints (e.g., race, class, gender) that keep individuals from a *true* understanding of how the world works and in turn liberate and empower them (Kincheloe & McLaren, 1994). According to critical theory, researchers are influenced by their own perceptions and experiences, highlighting that these are a result of culture, politics, race, gender, class and the mass media.

c) *Interpretivism*: It is conceptualised as having a relativist ontology with a subjectivist epistemology and is aligned with postmodern thought. The main principle is that there are multiple meanings and ways of knowing. Individuals are complex with different experiences and can understand the 'objective reality' in many different ways. Knowledge and truth exist in multiple forms based on individuals' experiences and ways of making sense of them; they are subjective and culturally and historically situated. Researchers' values are

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in its own distinctive historical process. History transforms all it touches and ontology is not abstracting ultimate principles of reality (Hacking, 2002).

inherent in all phases of the research process and truth is negotiated through dialogue (Denzin & Lincoln, 2005). Researchers cannot be completely separate from their own beliefs or values, so in turn these will inform the way in which data is collected, analysed and interpreted. The main aim of interpretivism is to acknowledge and narrate the meaning of human experiences and actions (Fossey et al., 2002). Meanings are of key importance to human life and the most fundamental aspect of society (Krauss, 2005). There are two main variations of interpretivism:

(i) Phenomenology seeks to understand the world through directly experiencing the phenomena; how individuals make sense of the world around them. The main principle is to gain a deeper understanding of the nature or meaning of everyday experiences.

(ii) Symbolic Interactionism is a theoretical approach focusing on understanding the relationship between humans and society. It refers to individuals being in a continual process of interpreting the social world around them.

The concept of this PhD is generally in line with the *Interpretivism* approach, as the main aim was indeed to try to understand individuals' motives, meanings and other subjective experiences, which are time and context bound. According to *Interpretivism* approach the phenomena studied are socially constructed and does not involve making broad conclusions or generalising and predicting causes and effects (Neuman, 2000). What we know

is always negotiated within cultures, social settings and relationships with others. Interpretivism offers a deeper understanding of a particular situation and tries to interpret these meanings in human behaviour, and that is how it differs from post-positivism and critical theory (Willis, 2007a). It is important to note here that one of the principle ideas of interpretivism, which is that researchers cannot be completely separate from their own beliefs, values or previously acquired knowledge (e.g., reviewing the literature). This is acknowledged not only by other key contemporary figures of qualitative research (e.g., Braun & Clarke, 2006), but by the 'opposite' paradigm of post-positivism that is moving away from the purely objective stance of positivism, acknowledging that researchers' values can influence the interpretation of the data. Indeed, as qualitative researchers we cannot be entirely objective and separate ourselves and our own values or beliefs from what we investigate. However, at the same time we should try to present as accurately as possible what individuals (i.e., participants) feel, think, believe and how they themselves perceive the world and make sense of their experiences. We should conduct research in a respectful manner, trying to use it as an opportunity to help the target population and recommend future research ideas that will investigate and further expand upon issues relating to the target population. We should be open to change, accept and seek multiple perspectives, use iterative data collection techniques and overall promote holistic research by going beyond the deductive or inductive approach (Willis, 2007a). It is acknowledged that there are limitations in qualitative research because of issues related to generalisation and reliability and by adopting an

Interpretivism approach, which is subjective in nature, can be an additional barrier in claiming generalisability.

On the other hand, certain topics and issues, which are related to *how* and *what* questions, rather than *how much* or *how many*, can be studied in a great level of depth. Researchers' epistemological stance is crucial as philosophy can provide the general principles of theoretical thinking and self-awareness, which are used to design, collect, analyse and interpret data and in turn try to obtain knowledge of reality or participants' reality. Yet at the same time, it should be acknowledged that these theories were developed as a response to the societal problems of their times (Willis, 2007b). Positivism was a radical perspective that emerged during the 19th century as a response to religious and metaphysical beliefs and it was later evolved to the post-positivist paradigm. Critical theory is an approach that had its foundation in Marxism and it was developed as an effort to evaluate and change the inequities of society. Interpretivism was developed as a critique of positivism in the social sciences, emphasising that reality cannot be explained by applying the same set of research methods to all problems and that researchers cannot simply be entirely objective. To conclude, all paradigms have their advantages and disadvantages and they should be used to help researchers identify a particular stance towards the nature of knowledge, which will underpin the research process. At the same time, we should take into consideration the contemporary way of thinking, conducting and presenting research, aiming to

tackle current problems and recommend solutions that will take us a step forward as individuals, as researchers and as part of the society we live in.

2.2.3 Methodological Justification

"*Qualitative research is a situated activity that locates the observer in the world. Qualitative research consists of a set of interpretive, material practices that make the world visible. These practices transform the world*" (Norman & Yvonna, 2011, p. 3).

This is a concept the present PhD research is based on, aiming to qualitatively assess the social and psychological impact of 'Transition from a civilian to a serviceman and from a serviceman to civilian', as seen through the eyes of the male veterans themselves and experienced by their female spouses/partners. Qualitative methods are used for revealing new information, uncovering dimensions such as beliefs, thoughts, feelings and motivations and for providing in-depth understanding of the research issues that embraces the perspectives of the study population and the context in which they live (Hennink, Hutter, & Bailey, 2015; Maxwell, 2005; Norman & Yvonna, 2011; Weinberg, 2002). A qualitative approach with quantitative elements (psychological measures) was taken to examine in detail the complex and sensitive issues surrounding the ex-military population, providing depth, nuance and context to this research. A qualitative approach was particularly suitable for this PhD research in order to:

- Build rapport and provide a comfortable atmosphere for participant disclosure and explore sensitive topics (e.g., combat experiences, injuries, mental health).
- Give voice to the study population and understand the complex issues surrounding the military community, exploring participants' beliefs and behaviour holistically about military, civilian life and their transition.
- Better understand beliefs, emotions, and behaviour from the perspectives of participants themselves.
- Understand 'processes', such as how participants used to make decisions, manage situations or cope with challenges before and after the two interventions (i.e., physical activity and storytelling) which were examined in this research.

2.3 Data Collection

2.3.1 Qualitative Data - Interviews

Qualitative interviews are a special form of conversation, as they provide a way of generating empirical data about the social world by asking people to talk about their experiences (Holstein & Gubrium, 2002). Even though the style of interviews may vary from highly structured to semi-formal guided conversations, all interviews are interactional (DeVault, 2002).

(i) Semi-Structured Face-to-Face or Telephone Interviews

In-depth semi-structured qualitative face-to-face interviews are used when seeking information on individual, personal experiences, offering the opportunity to capture rich, descriptive data about people's behaviours,

attitudes and perceptions, and unfolding complex processes (Bailey et al., 2015; Hennink et al., 2015; Janesick, 2000; Wengraf, 2001). Face-to-face interviews are considered the most productive mode for producing qualitative data, as they are an opportunity for the researcher to establish rapport and be able to answer to visual cues (A. Holt, 2010; Irvine et al., 2013). However, it is not always possible to conduct face-to-face interviews, especially when interviewing participants across geographically dispersed areas. An alternative option for collecting qualitative data is the telephone interview. On the one hand, telephone interviews are sometimes considered an inferior alternative when compared with face-to-face interviews and some of the main concerns include potential loss of contextual data and a compromise of rapport (Novick, 2008). On the other hand, telephone interviews are well-represented in research literature (Drabble, et al., 2016; Holt, 2010; Novick, 2008), and many methodological studies discuss the practical advantages (e.g., access to geographically dispersed participants, flexibility for scheduling, increased interviewer safety) and logistical conveniences (e.g., reduced costs) of telephone interviews (Cachia & Millward, 2011; Carr & Worth, 2001; Stephens, 2007). In addition to these benefits, studies show that there are other methodological strengths. For example, telephone interviews offer increased privacy for participants and allow them to feel more relaxed, being able to disclose sensitive information (Novick, 2008; Stephens, 2007; Sweet, 2002). Telephone interviews may also require the interviewees to be explicit and ask follow-up questions, rather than relying on participants' non-verbal cues (Cachia & Millward, 2011; Carr & Worth, 2001).

In-depth, semi-structured face-to-face or telephone, interviews were conducted for the purposes of this PhD research in order to understand the identity and background characteristics that may influence participants' stories and the context (e.g., socio-cultural and economic context) in which participants lived before joining the military and their 'journey' since. Also, to explore the meaning participants' attach to their experiences, the underlying motivations and beliefs and the impact that these may have on participants' decision-making and overall behaviour and coping strategies.

(ii) The Narrative Life Interview (NLI)

Life stories have gained respect and acceptance in many academic circles, such as psychology, sociology, anthropology and education and the value of personal narratives for understanding development and personality have been recognised (Atkinson, 1998). The narration of one's life story is more than just an account of events, but rather a respondent-led process that facilitates the interviewee to present their story in an organised (or sometimes disorganised) manner, to clarify and sometimes justify the life experiences. The life story technique allows the detailed study of complex relationships of experiences across time by covering the life story up until the present day (Atkinson, 2001). Narrative is an interpretive approach in the social sciences and involves using storytelling methodology (Mitchell & Egudo, 2013). The story becomes an object of study; it gives the opportunity to researchers to capture the individuals' stories, focusing on how they make sense of events and actions in their lives. Narratives as a research tool is appropriate to study subjectivity and

the influence of culture and identity on the human condition. A narrative approach enables researchers to better understand social representation processes, such as feelings, images and time and offers the potential to address ambiguity, complexity and dynamism of individual or group phenomena (Franzosi, 1998; Linde, 2001). Conducting a biographical-narrative interview is already a kind of psychological intervention. Rosenthal (2003), very wisely demonstrates the healing effects of storytelling in the context of qualitative social research, highlighting that social researchers naively assume that the interview cannot trigger processes of change in the participants. Researchers have the duty to show sensitivity and respect towards participants, making sure that the conversations they are guiding are supportive rather than burdensome for the participants. Researchers have to take into consideration the considerable psychological effects telling one's life story can have, especially when working with a vulnerable group of people or conducting biographical interviews.

The Narrative Life Interview (NLI) is a combination of McAdams' Life Story Interview (LSI) (McAdams, 2008) and NET (Chapter 1, Section 1.4.4.2-ii). The LSI enables research on life stories, including questions about key things in participants' lives; about the past as remembered and the future as imagined by them. NLI is a new interview technique, which allows participants to share the story of their lives. It combines key elements of (i) McAdams's LSI (biographical interview questions, including positive and negative experiences) and (ii) NET (the participant will get a written account of their narrative for self-reflection). The process of NLI can accommodate researchers to collect the

necessary qualitative data, but also actively show the gratitude and respect towards participants by providing a written account and time for reflection.

Two interview sessions are necessary to complete the NLI process. During the first interview session, the researcher will conduct the main interview developing their questions based on the principles of LSI. Participants will receive a written copy of their story a few days after the interview was conducted. They will have time to read their story and reflect on it. During the second interview session (after one week), participants will be able to recommend changes, add or remove information from their story and discuss their overall experience along with the potential 'therapeutic' benefits of this interview process. We recommend the use of appropriate psychometric measures (depending on the aim of the research), to better monitor changes on participants' mood, emotional or mental health and evaluate the process overall. Psychometric tests should be administered before the first interview session, after the second interview and for long-term monitoring after one, three and six months.

2.3.2 Developing Interview Protocols

The ongoing process of questioning in qualitative research, is an integral part of understanding the unfolding stories and perspectives of others (Agee, 2009). The process of developing clear questions will usually undergo a process of reflection and refinement (e.g., share a draft question with another researcher, or conduct a pilot interview) before the researcher get the questions to their final version (Creswell, 2007; Richards, 2005). Developing

effective qualitative questions can give shape and direction to a study and be the tools that will shape a study design and analysis (Agee, 2009; Maxwell, 2005).

Three Interview Protocols (IPs) (for the three studies), which were developed based on the purpose and objectives of this PhD research, were used by the researcher during the interview process. The structure of the IPs included introductory points, opening questions, key questions and closing questions. The design of the three interview protocols (for the three studies) started during the formulation of the research aims, after reviewing the literature and incorporating theory, and continued during the actual design of the research.

The IPs for the veterans' studies were developed using Castro's 'Military Transition Theory' (Castro, Kintzle, & Hassan, 2014) as a general guide, in order to explore all aspects of transition and better understand the lived experiences and perceptions of transition in civilian life and workforce in the short- and long-term. To gain a holistic understanding of transition, questions regarding participants' background, including their pre-military experiences (e.g., childhood, reasons for joining the military) and military experiences (e.g., perceptions of military, combat experiences) as well as their social and economic experiences during and after transition, were included.

To ensure the coherence, the IPs were categorised with subheadings of topics from the conceptual framework of each study in order to follow a logical order for both the interviewee and the researcher. Colloquial language relevant to the research topic was used, in order to reflect the context of the interviewees and make it easy for them to understand the questions (e.g. use of military

language). One of the main parts of the IPs was to explore and identify participants' feelings and cultural schemas. For that type of conceptual research questions, the researcher was planning to derive information through the narratives of interviewees (e.g., *"I felt sad when…")* but also ask in a direct way (e.g., *"What do you feel about…?"*), if further clarification was needed. The IPs include questions which are open and simple to allow participants share their experiences and describe how they feel without 'directing' their story. The questions also include a series of sub-questions to cover issues that will not be raised spontaneously by the participants. Detailed information regarding the structure of the interview protocols for each one of the three studies can be found in the method section of each chapters.

2.3.3 Psychological measures

Quantitative elements (psychological measures) were also required to obtain further details for participants' current mental health situation (before the initial interview) and better monitor potential changes (after the follow-up interviews) in their mental health after participating in the two interventions. The results from these questionnaires will be used in conjunction with the results from the interviews (i.e., follow-ups) in order to develop a broader and better understanding of the impact and long-term effects of the interventions on veterans' well-being.

As discussed in Chapter 1 (section 1.2.1 i) the most common mental health issues the veteran community faces are common mental health disorders (including anxiety and depression) and PTSD (KCMG, 2014). These mental health symptoms can either be triggered, or can be a consequence of military

experiences during training, deployment, combat, physical injuries, medical discharge, or the actual process of transition to civilian life (Rona et al., 2017; Fear et al., 2010; Demers, 2011). The researcher's aim was to establish trust and build rapport with the participants. However, for many veterans the idea of filling in reports and questionnaires, especially regarding sensitive topics like their mental health, can create a high level of discomfort (Ashcroft, 2012). Considering this, two questionnaires have been purposefully chosen.

- HADS (Hospital Anxiety and Depression Scale, Appendix 1)
- PCL-5 (Assesses the presence and severity of PTSD symptoms, Appendix 2)

These questionnaires have short and clear questions and are not time-consuming, but also provide the information needed to shape a better understanding of the current mental health status of the participants. Both measures are self-report instruments and can be used to monitor symptoms over time: HADS to provide a simple yet reliable tool and assess psychological distress in non-psychiatric patients and PCL-5 the presence and severity of PTSD symptoms (e.g., Blevins et al., 2015). Please see the sub-sections below for further information. As mentioned before, the purpose of using those two psychometric measures was not for screening purposes, but rather to better support the qualitative data from the follow-up interviews and obtain a clearer understanding of any positive or negative changes on these mental health aspects, after the participation in the interventions (i.e., Competitive Motorsport and Narrative Life Interview). Please note that cut-off scores were not used to include or exclude individuals from participation.

(i) HADS

The Hospital Anxiety and Depression Scale (HADS) was developed by Zigmond and Snaith in 1983 for hospital use to identify caseness of anxiety disorders and depression among patients in nonpsychiatric hospital clinics, and then made available to the wider general population (Zigmond & Snaith, 1983). HADS comprises 14 items, separated in two sub-scales: (i) HADS Anxiety subscale (HADS-A): seven items relate to anxiety symptoms and (ii) HADS Depression subscale (HADS-D): seven items relate to depressive symptoms. Zigmond and Snaith (1983) have proposed specific thresholds: a score between 0 and 7 does not indicate the presence of the symptoms of anxiety or depression, a score between 8 and 10 indicates the presence of the symptomology but to a moderate degree, and a score greater than or equal to 11 indicates a significant number of symptoms of anxiety or depression corresponding to confirmed cases. In an updated literature review on the validity of HADS (Bjelland et al., 2002), covering 747 papers, HADS was found to perform well in assessing the symptom of anxiety disorders and depression in somatic, psychiatric and primary care patients and in the general population. The concurrent validity of each of the two HADS scales, HADS Depression & Anxiety subscale, has been demonstrated with populations suffering from various pathologies, in different countries and with a variety of methodologies (Bocéréan & Dupret, 2014; Crawford et al., 2001; Hinz & Brähler, 2011; Poole & Morgan, 2006; Roberge et al., 2013).

(ii) PCL-5

PCL for DSM-IV is a 17-item self-report measure reflecting DSM-IV symptoms of PTSD. The PCL has a variety of purposes, including screening individuals for PTSD, aiding in diagnostic assessment of PTSD, and monitoring change in PTSD symptoms (US Department of Veterans Affairs). PCL has been already used in various studies that involve (ex-) military population (Bliese et al., 2008; Dobie et al., 2002; Keen et al., 2008), and general population (Freedy et al., 2010; Harrington & Newman, 2007; Lang et al., 2012; McDonald et al., 2015; Sherman et al., 2005; Walker et al., 2002).

The PCL was revised in accordance with DSM-5 (PCL-5) (US Department of Veterans Affairs). Even though the recommended *"standard"* for diagnosing PTSD is a structured clinical interview such as the CAPS-5 (Clinician-Administered PTSD Scale), the PCL-5 can be scored to provide a provisional PTSD diagnosis when necessary (US Department of Veterans Affairs). PCL-5 is a 20-item self-report measure that assesses the presence and severity of PTSD symptoms (Weathers et al., 2013). Items on the PCL-5 correspond with DSM-5 criteria for PTSD. The PCL-5 can be used to quantify and monitor symptoms over time, to screen individuals for PTSD, and to assist in providing a provisional PTSD diagnosis. The PCL-5 can be scored in different ways according to the National Center of PTSD (US Department of Veterans Affairs). For the purposes of the PhD studies "*a total symptom severity score (range - 0-80) will be obtained by summing the scores for each of the 20 items".* Current studies indicate that PCL-5 is a psychometrically sound measure of DSM-5 PTSD symptoms, which is useful for identifying provisional PTSD diagnostic status,

quantifying PTSD symptom severity, and detecting clinical change over time in PTSD symptoms (Blevins et al., 2015). PCL-5 has been used in research that involves service and ex-service members seeking treatment (Bovin et al., 2016; Wortmann et al., 2016), as well as general population (Verhey et al., 2018). Future psychometric work on the PCL-5 can be found in the National Center for PTSD website https://www.ptsd.va.gov/ (US Department of Veterans Affairs).

2.4 Ethical Issues

Ethical approval for all the studies was sought from the Medical School Research Ethics Committee at The University of Nottingham prior to conducting each study. All the materials to be used in the studies, including interview protocols, participant consent forms, information sheets, the psychological measures and where to seek further psychological assistance should participants feel distressed after the interviews, were seen and approved by the Ethics Committee (Appendix 3).

The potential to induce emotional distress in those who take part and narrate their stories to the interviewer was the main ethical problem which needed careful consideration. Veterans have often undergone traumatic experiences, which they may not have discussed with anyone prior to the interview, and this could lead to some emotional distress whilst narrating their stories. The in-depth interviews, and specifically the Narrative Life Interview as a procedure, encourage experiencing the emotions veterans felt when the trauma took

place in order for habituation to occur along with an improvement in their trauma symptoms.

In all three studies, precautions were taken to minimise participant distress. There was an element of psychoeducation prior to the interviews to normalize similar type of reactions as mentioned above for the participants and take them through potential benefits they might experience from sharing their stories. This also included providing explanations regarding how their data was going to be used and reassuring them of confidentiality and anonymity of participation. Participants were reassured that there would not be any negative consequences resulting from their participation. Participants were requested to read an information sheet about the study and to sign a consent form. Issues of anonymity and confidentiality were thoroughly explained, as were the reasons for using a Dictaphone to record the interview (to enable a detailed transcription to be made). All participants agreed to their interviews being recorded. Participants were informed that they could withdraw from the study at any point without further consequences. Any names mentioned in the interview, including their own, were changed. At the end of the interview, participants were provided with a list of places they can contact if they require further support, in addition to the contact details of the researcher who could direct them to local sources of support in their area.

2.5 Data Analysis

2.5.1 Qualitative Data

The two analytical methods that were used in this PhD are inductive Thematic Analysis (TA), following Braun's & Clarke's analytical framework and Narrative Analysis, following Polkinghorne's and McAdams' analytical framework.

2.5.2 Thematic Analysis

TA emphasises on identifying, analysing and interpreting patterns of meaning (i.e., themes) within qualitative data in rich detail. There are different versions of TA, which can be divergent in terms of procedure as they are underpinned by different philosophical and conceptual assumptions (Guest et al., 2012). Other qualitative analytic approaches, such as interpretative phenomenological analysis (IPA) (e.g., Smith & Shinebourne, 2012), grounded theory (GT) (e.g., Bryant & Charmaz, 2006; Glaser & Strauss, 1995), discourse analysis (e.g., Willig, 2003), or narrative analysis (e.g., Murray, 2003), are theoretically informed frameworks for research. There is either relatively limited variability in how these methods will be applied when analysing qualitative data as they are theoretically bounded (e.g., IPA), or there are different versions of the method from within the broad theoretical framework (e.g., narrative analysis).

- *Grounded Theory (GT):* GT (Glaser & Strauss, 1995) is better thought of as a methodology rather than a method. It uses a systematic set of procedures to develop a substantive theory about a phenomenon. There is a lot of discussion and debate regarding GT

due to the numerous original and emerging approaches. There are three main types of GT with three broad ontological and epistemological variants (Weed, 2017): classical GT (realist/positivist), post-positivist GT (realist/interpretivist) and constructivist GT (constructivist/interpretivist). GT was not considered for data analysis as (i) all versions of GT advocate the use of particular types of research questions to discover the participants' core problems and develop a theory to better understand these problems as experienced by them as well as how they deal with them (Mediani, 2017) (ii) it is usually achievable in a large research project (Pidgeon & Henwood, 1997) (iii) it has an inbuilt theoretical framework and ontological/epistemological assumptions as mentioned above. It is acknowledged that GT would be an interesting methodological choice if it was decided from the beginning, in order to use the appropriate research design and interview protocol according to the principles of GT. However, during the development of the study design of the three independent studies included in this PhD, the researcher's aims were not to develop a theory but rather an in-depth exploration of specific aspects of veterans' lives during transition along with their impact on them (e.g., how and why physical activity and specifically CM had benefited veterans and what was the long-term impact on their transition). The data analysis of specific parts of the interviews focusing on veterans' pre- and post-military experiences, which was

included in Chapter 3, was decided later during the process. Despite the enormous literature covering all the aspects of veterans' transition to civilian life issues still remain. As discussed in Chapter 1, the aim of Chapter 3 was to gain a more sophisticated understanding of British male military veterans' perceptions of transition and all the issues surrounding this process, from emotional to practical and identify patterns across the entire dataset. 'Military veterans' can be considered more as an umbrella term rather than 'a group of people'. So if it was to use GT in order to develop a theory about this group, a larger and more homogenous sample (e.g., health status, age group, military branch), would have been crucial; for example veterans from different branches of the military have different military experiences (including combat) and transition (i.e., specific procedures depending on the branch). Finally, the ontological and epistemological assumptions of GT are not in line with the theoretical framework of any of the studies included in this PhD.

- *IPA:* IPA (Smith, Flowers, & Larkin, 2009) is also better thought of as a methodology rather than a method. It is phenomenologically informed and has an idiographic focus. IPA would be an excellent choice for the study in Chapter 6, due to (i) the small sample size (nine participants), which is preferred in studies using IPA and (ii) the main aim of the study, which was to offer insights into how individuals (i.e., veterans' female spouses/partners) make sense of

particular situations/events/phenomena related to experiences of some personal significance (i.e., their husbands'/partners' transition to civilian life). However, researcher's initial aim was to interview more participants and did not design the research and interview protocol according to the principles of IPA. Even though IPA would have allowed the researcher to stay close to the data and focus on the unique characteristics of each individual participant, inductive TA (i.e., the method that was used), was equally an appropriate choice as it allowed the researcher to identify patterns across the entire dataset.

One of the benefits of TA as a research tool is its flexibility and theoretical freedom, which can provide a rich and detailed account of data (Braun & Clarke, 2006; Clarke & Braun, 2013). TA is not theoretically bounded to any pre-existing theoretical framework and therefore it can be used within different theoretical frameworks, for example, as part of the essentialist/realist framework and report participants' meaning and reality or as part of the constructionist framework by investigating the ways in which realities and experiences are the effects of a range of discourses existing within society. Braun and Clarke (2006) provide concise guidelines on how to undertake TA in a way that is theoretically and methodologically sound, while ensuring flexibility in relation to how it is used.

TA was used to analyse qualitative data in Chapter 3 (first part), 4 (first part), 5 and 6. The TA in all chapters was primarily inductive, as the aim was to code the data without trying to fit it into a pre-existing coding frame or analytical

preconceptions. As Braun & Clarke (2006) indicate, a TA usually follows a semantic approach considering themes as patterns of shared meaning underpinned by a central organising concept. A semantic approach was chosen when doing TA as with this approach the themes are identified within the explicit meaning of the data and the focus is on participants' stated opinions. However, it is important to note here that the analytic process involves a progression that goes beyond a simple description of the data. The aim of the analysis includes an interpretation, attempting to provide an in-depth account and present the significance of these patterns and their meanings in relation to previous literature (Patton, 2002). Reviewing the literature on issues regarding veterans' transition and the impact on them as individuals but also the challenges their families face during this period, played a key role on developing the interview protocols but also during the analysis and discussion process. Themes are distinct yet they are clearly linked back to the overall research scope. Even though this knowledge did not determine the development of the themes, it is important to acknowledge that researchers cannot free themselves of their past knowledge or epistemological commitments. A latent approach as Boyatzis (1998) describes, involves reading into the subtext underlying the data and focus on what participants' statements reveal about their assumptions and social context. It follows a 'coding reliability' approach to TA, which involves a coding frames precisely along with multiple, independent coders to enable interrater-reliability and the search for clear and fixed meanings. Yet in this approach TA is used in a rigid manner and it is underpinned by a positivist assumption that there is a reality,

which can be accurately captured if appropriate techniques are used while coding. These assumptions are not in line with the approach followed in this PhD, which understand coding as an active and reflexive process.

Full transcriptions were made and the transcripts (first and follow-up interviews) were coded to generate ideas and themes for discussion. This was done using the six-phase approach recommended by Braun and Clarke (2006, 2013) as the most efficient and rigorous way of conducting thematic analysis. This approach commenced with the researcher reading the transcripts several times to become familiar with the content. Preliminary analysis was then undertaken, which involved the production of initial codes from the data. Codes are a description (semantic content) and not an interpretation. They are interesting elements or information of the raw data that can be assessed in a meaningful way. Coding was systematic through the entire data set giving full attention to each data item and the tensions and inconsistences within and across the data were not ignored. Codes were then carefully examined in relation to the overall research aims of each study to ensure their relevance and then identify potential themes. During this phase, the analysis was re-focused at the broader level of themes, rather than codes. The sets of themes identified were discussed with the supervisors and refined to ensure that they are coherent, distinctive and relevant to the intent of each study. During this phase, the 'essence' of what each theme is about was identified, determining what was interesting about each one and why. At the same time, how it fits into the broader overall story that is told about the data in relation to the research questions, was also considered. While producing the report, the

analysis was broadened out beyond the 'surface' of the data, moving from a semantic (descriptive) level to an interpretative one, which is often related to the existing literature.

2.5.3 Narrative Inquiry

Narrative inquiry is a qualitative methodology and a process of thinking narratively about personal and human dimensions of experience throughout the inquiry. Narrative inquiry is an umbrella term; a means by which individuals' stories are systematically gathered, analysed and represented as told by them. It captures individuals' experiences over time, taking into consideration the relationship between individual experience and cultural context (Clandinin & Connelly, 2000). The key part of this narrative 'turn' in qualitative research is that human understanding takes a narrative form and selves and identities are conceptualised as narratively constructed. Yet there are many complexities surrounding narrative identities and selves as there are various conceptualisations from a range of scholars from diverse disciplines. On the one end, it is the '*thick individual - thin social relational*' view to the self and identity, while on the other end it is the '*thin individual - thick social relational*' view. Even though each perspective represents something different, their coexistence is sometimes possible despite these differences. The five main perspectives of narrative identity are [please see Smith & Sparkes (2008) for more detail]:

i. *Psychosocial Perspective*: Even though it is acknowledged that stories are constructed through socio-cultural factors and social interactions,

the individual and their unique interior configuration are given primacy over social. It is either believed that knowledge of the self and the world can be objective accompanied by an epistemological realism standpoint or that knowledge is socially constructed and it is impossible to know when the real world is accurately depicted accompanied by an epistemological constructivism standpoint.

ii. *Inter-subjective Perspective*: The nature and shape of identities and selves are both matters of individual and cultural concern. There is a commitment to the idea that there is no real world independent of our knowledge of it and the idea that it is impossible to know when the real world is accurately depicted accompanied by an interpretive standpoint. It is argued that researchers cannot simply stand outside their own social standpoint and fallible knowledge to gain access to a 'real' world, 'real' selves and 'real' experiences and actually know if these are being mirrored correctly. Within contemporary inter-subjective perspectives, it is also accepted that individuals are finite beings accompanied by a non-foundational standpoint. Individuals' self-narratives and narrative identities are a subjective sense of self-continuity, integrating their lived experiences and events in the plot of the story they tell about themselves. At the same time, they are also formed by the complex interactions among imagination, habits and significant others (Ezzy, 1998).

iii. *A Storied Resource Perspective*: Narratives are considered as social actions rather than an inner process, the individuals as culturally

immersed and the individual mind as the way to transfer culture, viewing. These views are mostly accompanied by a non-foundational standpoint.

iv. *Dialogic Perspective*: They consider culture as 'speaking itself' through the stories individual tell, with the decentralisation of the concept of self, playing the key role. These views explicitly commit to a non-foundational standpoint.

v. *Performative Perspective*: This is the far end of the continuum, adopting the '*non-individualist - thick social relational*' view to the self and identity. Similar to the dialogic perspective (but with a more radical stance), narratives are considered largely as storied actions, rather than internalised structures and social relatedness comes first by ignoring individuality and lived experiences.

As mentioned in the previous sub-section (2.2), the researcher's perspectives adopt the principles of interpretivism and that is why for the purposes of the narrative analysis and discussion of the findings the '*Inter-subjective Perspective'* of narrative self and identity is followed.

2.5.3.1 Methods of narrative data analysis

Narrative analysis refers to a cluster of analytic methods for interpreting texts or visual data that have a storied form. Narrative analysis is interested in the overall story along with smaller narratives within the story, which construct the reality the narrator presents their life experiences and events. The approach taken to analyse narrative data is open and depends on the aim of

the specific study (Jovchelovitch & Bauer, 2000). Different approaches to narrative analysis are categorised on the basis of whether they focus on the narrative content; the thematic version interrogating what a story is about, and the structural version asks how a story is composed to achieve particular communicative aims (Figgou & Pavlopoulos, 2015).

(a) Polkinghorne's analytical framework

Polkinghorne (1995) makes this important distinction between the '*Analysis of Narratives'* and '*Narrative Analysis*[7]*'* in his analytical framework, pointing out that narrative analysis includes unique and distinctive features and stands between the world of qualitative and arts-based research.

i. '*Analysis of Narratives'* relies on paradigmatic cognition, aiming to organise experience as consistent, while attending to its general features and common categories and characteristics. It aims to produce general knowledge from a set of evidence in a collection of stories, without focusing on the unique (or different) aspects of each story. Most often this approach requires a database consisting of several stories (rather than a single story) that the researcher will use to discover which notions appear across them. Two types of paradigmatic search are possible: (i) one in which the concepts are derived from

[7] Polkinghorne's term: It is used to refer to one of the *types* of analysing narrative data and not the *act* of analysing narrative data in general, which is what most narrative researchers use.

previous theory/logical possibilities and are applied to the data to determine if instances of these concepts can be found; and (ii) one in which concepts are inductively derived from the data and the researcher's aim is to develop concepts rather than imposing previous theoretically derived concepts to the data.

ii. '*Narrative Analysis'* depends on narrative cognition; it is a method of *emplotting* the data, focusing on the events, actions and other data elements in order to produce coherent stories as an outcome of the analysis. Narrative cognition focuses on the differences and diversity of individuals' actions and behaviours as well as the complex interactions that make each situation remarkable. Unlike narrative analysis of the paradigmatic type (i.e., '*Analysis of Narratives'*), the data used in the narrative analytic type are usually not in storied form, as the aim is to produce stories as the outcome of the research.

'*Analysis of Narratives',* using inductive analysis (i.e., option a-ii) will be used to analyse the data in Chapter 3/part 2. This is explained in greater detail in the method section of Chapter 3/part 2.

(b) McAdams' analytical framework

We live in a storied world replete with narratives and we interpret the actions of others and ourselves through the stories we exchange. Humans seek meaning and purpose in life and stories are the tool to create meaning from experiences (Bruner, 1990). Narratives are part of our daily lives in terms of

communicating with others and making sense of the world around us (Hutto, 2007).

i. *Narrative Identity*: Narrative identity is the concept of identity as a life story. It is an individual's internalised and evolving story that they construct to make sense and meaning out of their life and form an identity by integrating their experiences (McAdams, 2001). Narrative identity creates a coherent account of identity in time; individuals reconstruct an autobiographical past telling to themselves and others who they are and how they came to be, and presents the future in order to create meaning and purpose (McAdams, 2011). Life stories do not follow a predefined arc, but rather experiences and identities are constantly shifting, and storytelling is way to make sense of it. The narrative identity builds over time as individuals process, re-interpret and re-tell their stories; they are subjected to a range of social influences and highly affected by the themes and plots offered by different cultures (Mclean et al., 2001). Stories in general simulate social experiences and engage human emotions, but narrative identity is a special kind of story that integrates elements of self in a diachronic sense, showing how the self of yesterday has become the self of today (McAdams, 2018). Individuals create meaning from life experiences and when they do, it has important implications for identity and well-being. Narrative meaning-making consists of a set of developmentally acquired skills and individuals' developmental level may decrease

meaning making in narrative identity; for example, the same event could be interpreted differently by the same person in two different points in time, if they are lacking certain autobiographical skills that will enable them to process aversive life events in a psychologically productive way and recognise the important themes or insights from what happened (McLean, Breen, & Fournier, 2010). McAdams' (1995) three-level framework suggests that to know a person well, data must be obtained from the three distinct and nonoverlapping levels: (i) dispositional traits (ii) personal concerns and (iii) life stories, as those provide three very different formats for understanding a person. Level I consists of the broad dispositional traits drawn from the Five-Factor Model of personality, which are broad decontextualised descriptors that remain relatively stable across the lifespan (Widiger, 2017). Trait attributions are important, yet not enough as they tend to emphasize genetic predispositions. Level II refers to motivations, developmental concerns, coping strategies, values and life strategies within the individual's contextualised time, place and social roles. Level III, an individual's narrative identity, encompasses the internalised and evolving story of self when the events within the life story become part of the personality itself. Identity in adulthood is an inner story of the self, which connects the reconstructed past, perceived present, and anticipated future to provide a life with unity and purpose. Narrating life experiences is a complex process that not only reflects, but also creates modes of meaning-making. Beyond the content of life stories,

the narration per se is essential to understanding narrative identity. During this process, the identity is crafted, what and how individuals say and repeat while narrating, indicates who they are and where they stand in society. Creating a coherent sense of identity can lead to self-development as it helps the narrator to obtain a better understanding of self (Fivush et al., 2017).

ii. *Redemption & Contamination Sequences*: These two strategies, developed by McAdams (McAdams, 1998, 1999) concern how individuals make narrative sense of their experiences that entail significant transformation in affect. A redemption sequence involves the move from affectively negative life situation to a positive one, thus the bad is redeemed or mitigated and replaced by the good that resulted from this. On the contrary, in a contamination sequence the narrator depicts a transformation from an affectively positive life scene to a negative one, thus the good is contaminated or undermined by what follows it. Research into the relation between life stories and adaptation shows that when storytellers find redemptive meanings in suffering and adversity, they are able to construct life stories that feature themes of personal agency and exploration and tend to have higher levels of psychological well-being and adaptation to life (McAdams & McLean, 2013). McAdams' framework (both *Narrative Identity* & *Redemption Contamination Sequences*) will be used to analyse the data in Chapter 4/part 2. This is explained in detail in the method section of Chapter 4/part 2.

2.5.4 Psychological measures

Two psychometric measures (HADS and PCL-5) were used in the *Narrative Life Interview* study (chapter 4) and the *Competitive Motorsport* study (chapter 5). Psychometric measures were a useful tool to monitor potential changes after the interventions (either positive or negative). Due to the small and non-representative sample, the purpose of the psychological measures was not to be used independently, but rather in conjunction with the qualitative data from the follow-up interviews for both studies.

The Shapiro-Wilk test (Shapiro & Wilk, 1965) for normality was conducted in SPSS (IBM SPSS, 2016) and the results (for both studies) indicated that the scores on the HADS and PCL-5 are normally distributed in the population. Since the required normality assumption was met, a paired-sample t-test was then conducted in SPSS (IBM SPSS, 2016) to compare the pre- and post-test scores of depression, anxiety and PTSD. Further details can be found in chapter 4 (section 4.4.2) and chapter 5 (section 5.5).

2.5.5 Generalisability

Generalisation is widely-acknowledged as a quality standard and it is an act of reasoning that involves drawing broad conclusions from particular instances and observations (Polit & Beck, 2010). In qualitative studies, the issue of generalisation is more complicated and controversial than in quantitative research. For the purposes of this PhD research the qualitative sample is large enough to assure that most of the perceptions that might be important for this population are uncovered. Even though, data saturation was reached with no

more patterns or themes emerging from the data (Bowen, 2008; O'Reilly & Parker, 2013), the researcher continued interviewing participants to ensure that 'rich data' was collected and that the range of opinion and diversity of views was explored (Given, 2008; Saunders et al., 2018). The main aim of these intensive studies was to provide a rich, contextualised understanding of some aspect of veterans' and their wives'/partners' subjective experiences of transition from military to civilian life, rather than argue on the attainability of generalisability. However, it is important to ensure that insights from qualitative research are recognised as important sources of evidence for practice.

There are three models of generalisability, developed by Firestone (1993), which provide a useful framework for both quantitative and qualitative studies: (i) *Statistical generalisation* (extrapolating from a sample to a population), (ii) *Transferability* (providing detailed descriptions that allow readers to make inferences about extrapolating the findings to other settings) and (iii) *Analytic generalisation,* which will be explained below. Overall, generalisability models, like most models, are an '*ideal aim*' to be achieved by researchers, rather than an accurate depiction of what transpires in real-world research (Polit & Beck, 2010). Analytic generalisation is usually linked with qualitative research and its principle is in line with what was aimed to be achieved in this PhD. Analytic generalisation occurs through rigorous inductive analysis and interpretation of the data, along with strategies that address the credibility of the conclusions. For this to happen it is important during analysis to distinguish between the subjective unique perceptions that are relevant

only to particular participants and the information that is relevant to many or all participants. It is important to note here, that researchers make no claim to statistical representativeness, but rather assume that findings can reflect valid descriptions of sufficient depth and contribute to the development of conceptualisations of a particular phenomenon(Ayres et al., 2003).

Chapter 3: Life Transitions - From Civilian to Military & Military to Civilian Life

3.1 Introduction

A transition can occur when life events result in change and affect various aspects of an individual's life along with their societal roles, which can be disabling for many (Schlossberg, 1981, 2011). Military transition (both from civilian to military and military to civilian) requires navigation of a series of adjustments, including everyday routine, cultural norms, roles, reference groups, friendship networks and identity. For many, joining the military is considered as the transition to adulthood, which happens in a highly structured environment (Kelty et al., 2010). Military integration can shape values, worldviews and expectations and that is why military culture continues to be central during transition to civilian life; it is a form of adaptation, which requires identity negotiation along with the development of new cultural skills and understandings (Ray & Heaslip, 2011).

3.1.1 Research Aims

In Chapter 1, research on transition from military to civilian life was discussed along with the main issues facing the veteran community.

This Chapter aims to build on previous research in order to:

i. develop a more sophisticated and holistic understanding of British male veterans' perspectives regarding the practical and emotional challenges faced during transition to civilian life.

ii. identify the factors that facilitate or hinder their transition. The identification of links among all life experiences (i.e., before, during and after military service), will allow for an in-depth understanding of veterans perspectives and subjective experiences.

This chapter has two sub-sections, which include the two datasets from the two independent studies (i.e., Competitive Motorsport & Narrative Life Interview). Even though the interview protocols were developed to accommodate the specific purposes of each study, the questions regarding past experiences, military experiences and transition to civilian life experiences were very similar. However, since two different methods of data collection were used (i.e., a semi-structured interview and a narrative interview respectively) the datasets will be analysed separately in two sub-sections using two different frameworks: inductive TA using Braun's & Clarke's analytical framework and Narrative Analysis using Polkinghorne's analytical framework. Using two different approaches to analyse data, which explore the same issues, can be an opportunity to shed a light on different aspects of veterans' personal and subjective experiences and better understand their perspectives and personal points of view. A short discussion will be presented after each sub-section, aiming to summarise the key findings of each dataset. It is important to note that the results from both sections will be combined and discussed in light of what was already known about the issues facing the veteran community, along with limitations and recommendations for future research and practice, in Chapter 7 - 'General Discussion'.

3.2 Part 1: Data from the Competitive Motorsport Study

3.2.1 Method

This is a qualitative study based on semi-structured, in-depth interviews with male British military veterans. A more concise version of the method will be presented here, but further details can be found in the respective chapter (section 5.3).

3.2.1.2 Participants

Fourteen individuals living in the UK were interviewed. Participants were all male British military veterans. Veterans represented a wide range of demographic and military characteristics (Table 13 CM Participants' Demographics, section 5.3.2). Thirteen participants served in the British Army and one in the Royal Marines. The length of service varied between four and twenty-one years. The age range of participants was 25 to 51. Participants had to be physically injured (minor or severe physical injuries) to take part[8]. None of the participants had any form of therapy during this study[9].

3.2.1.3 Procedure

Participants were recruited via opportunity sampling through KartForce. For the purposes of this sub-section the focus will be on the questions centred on

[8] Most participants also suffered from mental health problems (some had an official diagnosis and some self-reported it). We acknowledge ill mental health as a key barrier of transition in civilian life and include it in the Data Analysis and Discussion, yet it was not part of the inclusion criteria for this study.

[9] Participants who took part in this study are noted as "PCM".

participants' pre- and post-military experiences and the challenges during their transition to civilian life. A semi-structured interview protocol was developed from these areas of interest (Appendix 5). Follow-up interviews were conducted but only for the purposes of the CM study (Chapter

3.2.1.5 Data Analysis

Full transcriptions were made and the transcripts were coded to generate ideas and themes for discussion. This was done using the established six-step guidance for TA (Braun & Clarke, 2006): reading and re-reading the data, producing codes, searching for and developing early themes and revising and refining themes. The analysis was primarily inductive, aiming to identify key aspects of the transition process (from civilian to military and military to civilian), topics that are common among the data and consider the ways veterans perceived and explained them. A semantic approach was employed to identify themes within the explicit meanings of the data as described by Braun & Clarke (2006). It is important to note here though that the analytic process involves a progression that goes beyond a simple description of the data, to an interpretation, attempting to present the significance of these patterns and their meanings in relation to previous literature (Patton, 2002). Quotations are verbatim, with non-verbal elements removed to improve readability. NVivo 11 software was used for data analysis (QSR International 2016). Discussions with the supervisors about the derived themes served the process of triangulation, ensuring that the themes were accurately reflected in the raw data.

3.2.2 Results

Analysis of the interviews yielded four key themes. These were: (1) *Perceptions of Military Service,* (2) *Expectations versus Reality,* (3) *Ambiguity & Complexity,* (4) *Searching for a new normal.* Themes and sub-themes are presented in Table 3.

Table 3 Themes Chapter 3/Part 1

Themes	Sub-themes
Perceptions of Military Service	*(i) The need to start afresh* *(ii) Self-growth: Learning through opportunities & challenges* *(iii) Building lasting relationships*
Expectations versus Reality	*(i) Feeling helpless* *(ii) Lack of loyalty* *(iii) Struggling to adapt to civilian life*
Ambiguity & Complexity	*(i) Loss of subjective-self identity* *(ii) Lack of understanding*
Searching for a New Normal	*(i) Feeling grateful* *(ii) Towards self-realisation*

3.2.2.1 Perceptions of Military Service

(i) The need to start afresh

Participants discussed their perceptions of military service and the factors which influenced their decision to enlist. Regardless of the life circumstances or personal and family experiences, participants considered the military as the only way to start a new life full of adventure, that would give them purpose, job stability and the opportunity to grow and become independent.

PCM4: "*It's just one of those things I always wanted to do. I was in the cadets when I was younger. I had some minor experience, I suppose, a few family members in the army and it's just something I wanted to do…*"

Growing up in an environment with military influences or gaining hands-on experiences in similar environments (e.g., cadets) encouraged participants to consider military service as a 'way of life', something they aspired to do and a great opportunity to build a new life. Indeed, participants who had a good socio-economic and educational background, described their endless need to live an active life full of unique experiences and adventures. Lack of educational aspirations and the ability to live the life they were dreaming of as civilians, led them to make the decision to enlist in the military.

PCM11: "*My dad was in the Forces as well. It was my choice but I was probably subconsciously influenced by it...I'd been surrounded by the army all my life, so it felt like a bit of natural progression*".

PCM12: *"I had a good upbringing when I was young […] in my teenage days I was very active. The army was definitely something I was going to do since I was a child, I think, you know... the main thing was because there weren't many things to do and I was an active person".*

For many, military service was perceived as an 'escape route', especially for participants who grew up in challenging environments with poor parenting and lack of practical and emotional support. The lack of emotional and practical support from parents had a negative impact on them, supressing their growth and independence. Some participants experienced abusive behaviours, either

emotional or physical, while others had lost their parents at a young age and had to grow up in residential institutes and social services.

PCM13: "*My mum died when I was very young… so I was kind of in a situation where my dad had a partner and she wasn't the nicest of people […] We used to get beaten, kicked, punched, slapped and I even got stabbed with a piece of glass by the so-called stepmother […] I was fed up. It was an escape, yeah […] that was me going up into the army".*

Lack of coping skills, aspirations and opportunities for personal development (e.g., low educational attainment, substance abuse, trouble with the law or mixing with the wrong crowd) led participants to seek out artificial methods of coping to relieve stress and avoid their responsibilities.

PCM2: *"I grew up in a bad area […] When I was at school, I got bored of getting educated […] I sort of grew up doing drugs, recreational drugs, not hard drugs but drinking and sort of causing trouble […] one day I just woke up and I got sick of just drinking and partying, so stopped doing all the drugs, got fit, joined the army, finally, at 21…"*

Life at this point was described as feeling trapped in a vicious circle, which only involved lack of opportunities, support and purpose. The need for a new beginning and the willingness to create a better future for themselves, was what helped participants achieve a level of self-realisation and start making conscious decisions. It was argued that military service has long been considered 'a gateway', for many young adults, including participants, who

perceived military service as the ultimate opportunity to become independent, build character and learn responsibility, focus and discipline.

(ii) Self-growth: Learning through opportunities & challenges

Serving in the military was a physically and psychologically intensive process yet it was perceived as a good career choice overall, which offered job satisfaction and the opportunity to specialise in the things individuals were passionate about. Numerous positive outcomes resulted from military service; it led to personal growth, self-improvement, positive emotional experiences. Gaining strong values and transferable skills, such as resilience, discipline, leadership, management and communication skills, were considered valuable for their life during but also after the military.

PCM4: *"It just kinda gives you good life skills, I suppose, straight from school, learn how to look after yourself… just kinda keep all your admin together and, yeah, it helped a lot".*

PCM7: *"The big thing for me was having a career path... doing well, rewarded with promotion, more money and, ultimately, a long career […] I thought if I'm gonna do that, why not do it as an officer and kind of open up another level to my career and keep the thirst and the hunger there to keep on progressing"*.

The practical and emotional challenges involved in combat, after experiencing a traumatic incident or suffering physical injuries were discussed. Each participant had a unique story to tell yet all of them talked about situations

where they had to witness and cope with horrible situations and near-death experiences while taking part in military operations.

PCM7: *"my first tour was 2006/2007 and we had a pretty big ambush… I remember the overarching feeling... like when am I gonna be in a position where this is over and I can have a cup of tea… when are we then gonna be safe again […] Even now, thinking about it, it's like that's the hairs on the neck distinctive feelings, standing there going, right, how does this end?".*

PCM12: "…we'd seen lots of small children mutilated on the soil, little… just gravel, you know, that was quite a horrific experience for six months while we were in Kosovo. That's where it stems from, my… a lot of my anxiety from 1999. But after Afghanistan, that's when my depression started tickling […] there's lots of different situations where people were blown up and people shot and… It was a quite dangerous place, it was a very hard tour…"

At the same time though, participants stand strong in their opinions regarding the 'risks of the job', acknowledging it can involve all the above. It was highlighted that these experiences played a major role in their grasping of the incredible risk of military operations in real life, which was completely different from training. This realisation increased their understanding of what 'serving in the military' actually meant and at the same time gave them emotional strength and an opportunity for self-growth and self-realisation. Coming to this mindset was critical, as it helped them to adjust to the new situation, for example cope with emotional imbalance, physical injuries (minor or severe),

witnessing violence or the death of a comrade. The importance of making the decision to demonstrate resilience by accepting and facing issues surrounding ill health was highlighted as the key factor of successful coping.

PCM3: "*I just got to the point where I thought, shit happens, I can either be depressed out here, sit on my bed and do nothing, or I can move on with my life and try and do stuff […] So, there's no point in being, oh, I wish I didn't do this. You just move on. You've got to...*"

Reflecting on their military career, participants concluded that it was not just a career choice but a way of life, both an 'occupation' and a 'vocation', which had an overall positive impact on their lives. It was the demanding military lifestyle that was making everyday life exciting. Participants explained how proud and passionate they were about all the things they were able to achieve and the skills they have learned while serving.

PCM3: *"…I enjoyed Afghan. That was really good, actually, to be honest. Like, I know I got blown up… actually prior to that it was good"*.

PCM6: *"No, I don't regret anything that I've done […] Well, I suppose I do regret becoming injured and being forced to join civilian life again […] To be honest, if they rang me up now and said we've got a space for you, I would go back in a heartbeat, injuries or no injuries. You know, I just miss the lifestyle".*

Notably, regardless of all the negative short- and long-term consequences, including traumatic experiences, mental health issues or permanent physical injuries, participants did not regret this life changing decision.

(iii) Building lasting relationships

Comradeship was regarded as a unique kind of friendship not only while serving, but also in civilian life. Sharing the same moral code and values, mutual self-sacrifice, teamwork and covering for each other, contributed to individual bonding and unit cohesion. The strong sense of camaraderie made participants feel as part of a family and acted as a buffer against emotional and practical challenges during and after military service.

PCM4: *"I suppose that brotherhood's still there, really. So, you can look after each other, it's all the same. The banter's there. I don't think it ever goes away, really. You cannot see someone for a couple of years and, you know, you'll see them again and it's like you saw them last week, you know".*

The support from comrades was a vital contribution on participants' well-being, regardless of their experiences and severity of their problems (e.g., physical disability, mental health issues). It was acknowledged that being able to talk to other injured service members was reassuring. Being with people who were able to listen and be supportive, without trying to 'fix' them, buffered the impact of emotional distress during these stressful periods and helped participants keep things in perspective.

PCM8: *"I mean, I got injured with two other guys. So, obviously I'd include them and we'd just... I mean, considering everything bad that just happened, we just had the biggest laugh ever in hospital… just taking the mickey out of the nurses and the doctors and we were just having a laugh…"*

The bond among service members was described as strong, timeless and unique. It was argued that social behaviours which can be judged negatively by civilians can be acceptable in the military, for example expressing themselves in specific ways, share jokes and have conversations, which may not make sense or be applicable to 'civilian social norms'. This is another factor that contributes in maintaining the bonds of military friendship so strong.

PCM11: "*the friendships that you forge with military people last forever. I still speak to my army friends on the phone and it's like you've... we might not have spoken for 12 months or two years but when you pick the phone up, it's like you've never been apart…*"

The military values embedded in military culture are reflected in both service members' and veterans' individual behavioural decisions and choices. These values are so strong that they can bring service members and veterans close even if they do not know each other, something that, according to participants, appears to be a key difference between military and civilian population.

3.2.2.2 Expectations versus Reality

(i) Feeling helpless

Military personnel are highly trained, skilled, and resilient yet there is no 'perfect preparation' for the extreme danger and deadly encounters of military conflicts. It was explained that even the strongest and most experienced individuals can be completely impervious to the traumatic shock and stressful aftermath of military operations. For many, these traumatic incidents had a long-term negative impact on their well-being and mental health, which was a

realisation that came later in life.

PCM1: "*I lost my bladder and bowel and all that sort of stuff. Then I started developing... having dreams, seeing stuff that was happening when I was away and doctors doing stuff to me has made me worse… and then started getting really anxious".*

PCM6: *"I guess I was naïve enough to hope that things would get better and I'd be able to pull myself out of the mind-set that I was in, like I did the first time. But that couldn't… I couldn't… The more I tried to help myself, the worse it got".*

Most participants argued that they were in denial and avoided dealing directly with stressful demands. Ignoring disturbing feelings or thoughts only allowed them to live in the midst of a difficult situation without having to address the cause and overcome the problem. Avoidance coping was related to poor outcomes and sometimes had serious repercussions on their mental health.

PCM12*: "I broke down and I couldn't cope with my job anymore. And then I went into a psychiatric unit in London … I was there for four weeks, I think, and then, again… After that time it's been ongoing, really, to despair. I've been in hospital two or three times. I've tried to commit suicide once".*

Physical injuries, especially the loss of body parts, presented multi-directional challenges and had distinct but also overlapping psychological consequences. The psychological reactions among participants varied greatly depending on their unique situation. Avoidance coping was also apparent among participants with ill physical health, who tended to avoid facing the new reality (e.g., loss of

limbs). Participants experienced different stages of grief, such as denial, anger, attempts to jeopardise their rehabilitation plan, feelings of passivity and being overwhelmed. The necessity of inner-strength and resilience needed to accept the new reality, move forward and learn to live with a permanent injury was highlighted during the interviews as one of the biggest challenges faced in life so far.

PCM8: *"…like getting injured and then the recovery from that. That's my massive low point […] seeing everyone going to do stuff and you're not doing it and then they're piling on... like add stuff, just making you feel really down about being injured and like... It's bad enough as it is"*.

What was common among the interviews when discussing the emotional or physical consequences of military service was the persistent feeling of helplessness and lack of control during this period. Inability to perform job duties and responsibilities in a manner that reflects the highest professional standards put participants' future in the military in jeopardy.

PCM2: *"I was an angry person first 'cos I had a really good career in the army. I was gonna really progress and then all of a sudden, you know, I didn't have anything".*

Participants perceived military service as an exhilarating career choice and all of them wanted to continue serving for many years. The unpredictable nature of discharge along with the consequences on mental and/or physical health led to adverse emotional effects. For those who were not able to resolve anger issues and overcome self-doubt, it was the beginning of a vicious circle that

continued during their transition to civilian life. These thoughts created emotions that confused participants and ultimately eroded their own understanding of themselves.

(ii) Lack of loyalty

Reflecting on their military service and the way these experiences shaped them as individuals, participants felt proud and grateful regardless of the emotional or physical consequences. However, feelings of disappointment or sometimes betrayal were common among the interviews when discussing issues regarding the military as an organisation and the ways their situations were handled. Participants described situations, which made them feel frustrated and mistreated. For example, forced to continue training or be deployed despite physical injuries or situations where military doctors would ignore signs of potential physical injuries, which later led to deterioration of the problem or long-term impairments.

PCM2: *"I tried to get medical treatment and they told me it's no problem […] it was my left leg I injured but my right leg overcompensated for my left leg and I started getting complications […] what I realised is that they didn't really seem to care that I was injured […] I actually did one more tour of Afghan injured […] they lied on my medical records because I was the best person to go for this unit with all my qualifications".*

Participants talked about incidents of bullying and harassment, which crossed the boundaries of robust military training and created a hostile work environment. The challenge to cope with these types of situations emotionally,

but also practically (e.g., speak about it or report it), was highlighted by many as a key barrier in the effective resolution of problems in the military.

PCM6: *"I had an episode where I was being bullied by a female non-commissioned officer and she thought it was funny because I just let it keep happening... I guess she thought I was weak […] people from other units saw how I was being treated, they thought it was okay for them to do it and one day at work I just completely lost it and took quite a large overdose of various different tablets".*

Even though technically service members can talk to medical staff about their emotional struggles, the fear of the consequences, such as being judged or setting their career at risk, was a major barrier. Many participants argued that a solution would be the opportunity to disclose personal information to an independent professional, who does not get involved directly with their seniors.

PCM8: *"More things they need to do is like they need to have someone that you can talk to about anything and everything. Like they say, oh, like you can talk to anyone but it's not like that at all. If you talk to anyone in your chain of command, it can potentially really impact you and you don't want that […] but then they know all the* [medical] *officers so you don't feel you can talk to them either […] it's a bit weird".*

Another issue raised by participants was the process of medical discharge. This period is crucial for service leavers in order to prepare themselves practically

and mentally for transition. Participants expressed their disappointment for the way the process of transition was handled highlighting the lack of tailored support during this period. Additional responsibilities, for example participation on tours or in training, hindered the process by obligating participants to sacrifice valuable time from their preparation to leave the military. For some, it was consuming and exhausting process, which made them feel 'like a number', rather than an individual who deserved support and guidance.

PCM12: *"I knew there was something wrong with me when I admitted it to the army… and that's when I got admitted to a psychiatric unit […] it was the worst experience of my life, going through the whole medical discharge process. It was a long and winded process […] I think it should have been resolved quicker and then there would have been less problems. It was as if I was digging myself my own grave because of the process system took that long…"*

Preparation for civilian life should be tailored around health issues, age, education or marital status, as not all service leavers have the same needs. Many times, participants had contacted armed forces charities to ask for financial and career advice or support for mental health problems, since the military did not provide them with the appropriate information and guidance to tackle challenges that may occur in civilian life.

PCM13: *"I would say stop relying on charities to pick up the pieces. I think the MOD has a big reliance on voluntary charities to pick up the broken pieces of*

the souls that walk out the door and it shouldn't be like that. They should take responsibility".

What was common among the interviews, especially among participants who felt mistreated while serving, was the additional emotional struggle and practical problems that occurred due to the situations described above. It cost some of them their military careers and impacted on their transition in the long-term, developing a vicious circle of anger and disappointment.

(iii) Struggling to adapt to civilian life

Employment and economic transition are crucial parts of the re-adjustment to civilian life. Military experience did not always benefit participants when looking for civilian jobs. It was argued that civilian employers' misguided perceptions or unfamiliarity with the military culture could be a potential barrier in obtaining employment, even when participants were able to present their key achievements or transferable skills. Participants explained that the most common excuses were either the lack of direct work experience or the belief that they would not be able to adapt to the company's work culture.

PCM8: *"It* [my military experience] *didn't help with that. They thought that it would be too much of a culture shock, me working for them […] Like 8 years military experience, I have culture shock far worse than changing jobs".*

Medical care and the transition from the military health system to the NHS was an important part of the reintegration process. Depending on their physical or mental health status (e.g., injuries, amputations, emotional struggles) participants had different experiences. Key issues among the interviews were

the lack of communication and interest from the military regarding their progress, inconsistency and lack of tailored support from civilian services.

PCM11: "*…whilst I was still serving and I was getting my rehabilitation it was fantastic. Not so much when you get out. It's like you're forgotten. The day you get out the army they completely sever ties with you. You don't hear anything…"*

PCM13: *"…the sort of third-party consultants wouldn't take me seriously […] and whilst this was all going on, the pain was getting worse, the instability was getting worse. I fell down the stairs. I've forgotten how many times the leg would just give way underneath me".*

According to participants the civilian health care system was neither effective nor efficient. They complained that it took a long time to be given an official diagnosis by the doctors or mental health professionals and be treated effectively in a timely manner. This led to exacerbation of their health issues and had an additional negative impact on their wellbeing and efforts to re-adjust to civilian life.

PCM6: *"I've only just been diagnosed with PTSD and we're talking 2007 to now, so we're talking nine years. It's taken them nine years to diagnose me with PTSD".*

A key issue, especially for those who suffered from mental health problems, was the difficulty to establish an honest communication and build bonds of trust with clinicians. This was either because of the latter's lack of knowledge

of the unique needs of ex-military personnel or because in every appointment they had to see a different clinician and go through the same procedure without making any progress. The lack of continuity created inconsistency and the therapy session was losing its value as participants did not feel comfortable to open up.

PCM5: *"It was every three months, the appointment was, and every time I went back it was another new doctor because they were on a six-week cycle. So... And every time I went... You see, when someone has mental health issues, the best way to help them is consistency and a feeling of control […] I'd come out absolutely exhausted… and feel like I hadn't really achieved anything".*

Overall, therapy, such as counselling, was a controversial topic. A small number of participants who managed to have therapy sessions with the same professional, were mentally ready to open up and reach a steady state of personal growth, found some benefits in therapy. Yet they did not consider therapy as a key factor of their progress. Even though many participants were trying to move forward and improve their lives, they believed that therapy would be a step back rather than a step forward. It was argued that having to discuss past traumatic experiences with a professional who they did not know or trust, would be more harmful than beneficial and instead of achieving something positive it would cause additional emotional distress.

PCM2: "*I don't agree that therapy's good. This is why I've avoided it, because I think if they keep picking at my head, then I think my head will explode […] I*

think it would be like digging stuff up. It's away in a very dark place and I'm happy now, you know… I think I'm happy in myself with it being locked away".

Experiences with armed forces charities differed among the participants. Issues raised were administration delays and inconsistency in communication and support offered, which led to more confusion and disappointment.

PCM6*: "I found Combat Stress online and I referred myself to Combat Stress. I rang them up, told them about my problems and that's where I started getting help. But that didn't last very long because of my condition being as complex as it is. They couldn't support me in the way that I needed to be supported […] I was waiting for a bed, basically, and it took them three years to sort their admin out…".*

However, it was generally acknowledged that charities played (and still do) a significant role in their efforts to recover and re-build a purposeful life in civilian society. The key elements that were valued the most from participants, were the guidance and emotional support offered along with the companionship and opportunity to be in a familiar environment.

PCM12: "*I'm on the WIS list, which is Wounded Injured Soldier list. So, they send you e-mails to keep in contact - would you like to go away on a break here or would you like to go here […] if I wanted to go and talk to them, I could go back to. And that was on the Help for Heroes, not the army, though".*

Overall, what was common among the interviews and discussed in a tone of disappointment was the perception that the necessary support and guidance

offered during transition was from charities/non-military organisations and not from the military (as an organisation) itself, which was a shocking reality for many.

3.2.2.3 Ambiguity & Complexity

(i) Loss of subjective-self identity

The ambiguity and freedom of civilian life, opposed to the rigidity and lack of autonomy in the military, was not always easy to cope with. It created frustrations with others and made participants feel overwhelmed by not being able to manage the new reality. Regardless of their age, marital and financial status, participants argued that moving from a strict daily routine to having to create their own 'civilian routine' (e.g., worry about 'how' or 'when' to do something) was a culture shock and sometimes very difficult to overcome.

PCM10: *"I think more what people tend to struggle with is the adapting to civilian life. You know, you don't have everything laid out on a timetable for you with your meals at a certain time and all your kit given to you. It's a lot different, you know. You have to get up in the morning and actually motivate yourself…"*

Many problems arose due to the lack of preparedness, at an emotional (e.g., lack of support) and a practical level (e.g., unemployment), during the transition from the military to civilian life. This led some participants to very '*dark periods'* of their lives; for example, isolation, inability to cope with serious mental health problems (e.g., PTSD or depression), financial, employment or housing problems.

PCM12: *"I got medically discharged four years ago and I'd been… quite a loner since that, you know. I live indoors a lot. I don't go out much […] I don't sleep very well… I still get dreams and all that but I can control that in the house because I'm in control of the house, if you know what I mean. It's my safe place… outside the house is when I get stressed out…"*

It was explained that this challenging period of transition 'was just a blur', filled with negative emotions, such as extreme sadness, persistent anger, fear, anxiety or guilt. Being beset by these intense emotions made it difficult to cope with, and consequently affected their ability to think and act rationally or perform in an efficient and functional manner. Escaping reality was described as the greatest need during this challenging period and maladaptive coping strategies were employed trying to achieve it. Substance misuse, including mainly alcohol and sometimes drugs, self-harm behaviours, suicidal thoughts or suicide attempts were common among participants.

PCM1: *"…I went through a week of not sleeping. It really messed with my head. And this was all happened in the space of about 3 weeks and I was still feeling suicidal […] I felt like I was going to be a failure to my kids because I was going to be a civil dad…"*

PCM5: *"I'd get myself so worried about it that I was like drinking heavily to... would like drink like half a bottle of whiskey or something and then get up just to go to sleep and then get up in the morning and then go to work […] I couldn't cope…"*

Lack of motivation and purpose in life challenged participants and hindered the process of transition mainly at an emotional level, which in turn led to practical problems, such as maintaining healthy relationships or finding a job.

(ii) Lack of understanding

Spouses/Partners

Participants who were married or had an intimate relationship argued that the problematic nature of their transition to civilian life had implications, sometimes serious, for their marriage or intimate relationships. It was reported that the inability to adapt to a new life and daily routine as civilians, negatively affected their marriage/relationships. What was acknowledged by many participants as a key barrier was the challenge of understanding their own thoughts and feelings in order to improve their behaviour towards their spouse/partner. This was a major source of frustration and became the reason for constant arguments, which never led to a solution and sometimes triggered uncontrollable aggressive behaviours or violent outbursts.

PCM2: *"…I mean, two years ago I was a wreck, I couldn't cope with anything […] I used to be married as well and I turned to drink and I smashed my house up one day […] I don't know how you stop doing that and how do you stop being angry at people and doing all that, and that's the thing, you know, the transition…"*

Especially for participants who were married or had children, these situations were even more challenging as they produced constant feelings of shame and guilt. Lack of communication and understanding between the couple,

increased the difficulties in re-establishing a strong relationship with their spouse/partner or children. For participants this was a heavy burden to carry and sometimes very difficult to overcome.

PCM5: *"it can be a source of frustration for me because I don't feel that I get involved enough with them* [his children] *and I feel like I get easily frustrated and agitated around them sometimes and it's quite... I don't feel like a very good parent because I just […] I find it hard enough to deal with my own situations..."*

Indeed, it was reported by many was that having a spouse/partner did not automatically mean that the necessary support to overcome practical or emotional difficulties was received.

PCM2: "*I tried but I don't think she could understand how I get stressed and the problems in my head and everything […] the last year was ridiculous. The police would come to the house every time I had a drink 'cos we argued, I trashed the house up, and I felt worthless...".*

Feelings of loneliness were common among veterans, who many times decided to abandon all efforts to improve their personal development and isolate themselves thinking no one could understand or support them effectively.

Family

The need to be understood by others was common among the interviews when participants discussed issues surrounding social support, acknowledging how challenging relationships with civilian family and friends can become.

PCM1: *"I'm surrounded by my mum and my dad and my family trying to do everything for me. They don't realise I've got all this that I'm trying to deal with, and yet they're smothering me. And I'm like, give me some space to breathe […] that then changed the relationship between me and my mum… She keeps me at a distance because she doesn't want to get hurt…".*

It was reported that even though family members (e.g., parents) acted like carers when needed, trying their best to support them, miscommunication, lack of understanding or empathy towards their physical and mental health led to constant complications and arguments.

3.2.2.4 Searching for a New Normal

(i) Feeling grateful

Spouses/Partners

Emotional support offered by wives and partners was crucial not only for participants as individuals but for maintaining a strong healthy relationship despite the challenges. What was important for participants was that their spouses/partners were able to show empathy and accept them for who they were. This allowed them to have the necessary space and time to recover from mood swings or emotional distress, avoiding miscommunication and arguments.

PCM6: *"If I hadn't have met K., I'd be dead […] She sees every side of me, whether it's dark or…and she's fine with that […] I mean, it's been three weeks sometimes that I've had my headphones on and I haven't even spoken to my wife and she'll just bear as and when I'm gonna snap out of it…"*

PCM7: *"S.'s been fantastic with her support of me. We've always explained to the children why I act like I do […] she always does her best not to sort of make the situation worse. So, she'll basically just leave me alone, you know, and she'll understand and recognise the signs of when I'm having a bad time…"*

Feeling understood by their spouses/partners was crucial in maintaining the balance in the relationship; for example, having the necessary space and time to recover from mood swings or emotional distress, while trying to tackle their own personal problems and the problems that occurred in the relationship. This was an important step towards establishing an honest communication and feel more comfortable opening up by discussing their intrusive thoughts or aspirations for the future. In turn, this reduced the relationship stress and allowed their spouses/partners to better understand and accept them for who they were and who they were trying to become.

PCM8*: "I now live with my fiancé and like… I'm learning how to be a proper human again […] I was telling her everything, getting everything off my chest like […] I've said some really bad stuff to her… But she finds it funny as well. She's got the same level of humour as me and so…"*

What was also discussed was that the more spouses/partners know or can understand about the military mindset and culture, the more able they were to show empathy and effectively support them during challenging times.

PCM7: *"The advantage, I think, of a spouse is they're normally living your life with you, so they get the military and sometimes, if you put civilian parents or*

a civilian sibling, they can't really relate. They can say the platitudes and trying to comfort you but that can sometimes wind you up…".

Participants who were married or in a relationship while serving in the military, highlighted the value of being with someone who has knowledge and experience of the military environment, as it improved the quality of the support offered by their spouses/partners during transition to civilian life.

Family

The importance of social support, including family and friends, provided a buffer against various adverse life events during transition, giving participants a broader focus and positive self-image. Participants who were close to their parents said that their support and understanding played a significant role, helping them to build emotional resilience and be more efficient.

PCM10: *"I was very lucky that I've got a close family and a couple of my friends, you know, were good about it and I was able to lean on them about it […] my dad's served, he could tell when I was having a tough time. So, he was very good at being able to tell when he needed to talk to me about it and get it off my chest…"*

Participants highlighted that the support and patience their family demonstrated helped them understand themselves better and move forward by facing their problems or disturbing emotions and ultimately achieve personal growth.

(ii) Towards self-realisation

The way participants responded to all the challenges they had to face during their transition to civilian life (including ill physical/mental health, personal or professional challenges) varied greatly. Each one had their unique story and way to manage practical and emotional difficulties. Some participants argued that their need to be more self-sufficient and remain independent was more important than relying on others for help. They recognise the value of social support yet they decided that keeping some distance and continue facing challenges by themselves was a better way of coping and adjusting into civilian life.

PCM4: *"I suppose family obviously help and stuff but there's only so much they can do and you have to do a lot by yourself […] I didn't feel like I needed anyone to particularly look after me… I suppose I wanted to prove to myself I could still look after myself and... I suppose if you get too much help and you rely on other people too much..."*

Over the years, after leaving the military, participants tried (sometimes successfully and sometimes not), to find ways to cope with hardships, actively cope with emotional distress, create a support network and find new purpose and motivation in life. Employing a more optimistic outlook on finding solutions facilitated participants to resolve challenges and progress over time.

PCM2: *"Since I've been a civilian I've been very busy with a career […] I'm working really hard now, building a career, and then hopefully one day I can start relaxing again […] I think I've just turned everything negative into a*

positive. It's the best way to do it. It catches you out every now and then and then you sleep, you get over it and you stay happy".

PCM3: "I like the freedom. I go to Egypt quite a bit to do scuba-diving and the place where we stay and camp […] I love scuba-diving. Well, there's just something about like being under the water, you can't hear nothing around you, you're just there all on your own...".

Some participants tried to be productive, find a new purpose by building a new career, find motivation in leisure activities and avoid isolating themselves by spending time with fellow veterans, friends and family. It was explained that, despite the numerous challenges during transition and in the short- and long-term, it was a conscious choice to try and create a balanced life by not letting things they cannot change keep them back.

3.2.3 Discussion

The analysis of the first dataset provided a great deal of information regarding veterans' subjective experiences, the practical and emotional challenges faced during transition to civilian life and potential factors that may have facilitated or hindered their transition. The current results indicate that veterans' perceptions of military service were positive before enlistment and remained positive regardless of the various emotional or practical difficulties that occurred over the years.

Veterans who participated in this study represented a wide range of demographic characteristics. Some of the participants grew up in deprived

areas, with lack of parental support and were involved in anti-social or risky behaviours. While others grew up in families with good socioeconomic status, caring parents and higher levels of belongingness within their schools and communities. Research on military enlistment decisions indicates that young individuals join the military for a variety of economic and psychological reasons (Bachman et al., 2000; Eighmey, 2006; Gibson et al., 2007; Ginexi et al., 1994; Kilburn & Klerman, 1999; Lawrence & Legree, 1996; Spence et al., 2013; Woodruff et al., 2006). Indeed, what was common among all participants was the need to become independent by securing a stable job, find new, exciting opportunities that would motivate them and give them purpose by living a life full of adventure. Military was considered a great opportunity, which would combine both job stability and an unconventional yet purposeful life.

Military service generally, rather than war specifically, is considered a life-changing experience. Findings suggest that military service was a transition to adulthood, when veterans managed to develop lifelong skills, such as resilience, discipline, sense of responsibility and leadership and in turn achieve self-growth. Current findings are broadly consistent with previous military research (e.g., Elder et al., 2009; Gade, 2009), suggesting that overall military service is perceived as a life-course turning point and it can be significantly influenced by many factors. For example, entry at a relatively young age, the negative experiences the individual may have while serving (e.g., be exposed to traumatic events) or the positive ones (e.g., a successful military career). The numerous risks associated with military service and the realisation of how horrifying combat can be in real life, were acknowledged by all participants, as

they themselves had suffered the consequences. All participants were physically injured and most of them had developed mental health problems as a result. It is well-outlined in the literature that military experiences, such as deployment and exposure to combat are associated with increased risk of mental health problems, such as PTSD, major depression, substance abuse, impairment in social functioning and in the ability to work (Hoge et al., 2004; Kang et al., 2003; Prigerson, Maciejewski, & Rosenheck, 2002; Rona et al., 2007). Despite this, military service was associated with high levels of pride and was considered one of the best life decisions made so far. Certain expectations, which were not necessarily unrealistic, made veterans feel lost and confused when facing reality, which led to many long-term emotional and practical difficulties. The key issues that results indicate are mainly related to the way physical and mental health issues were handled by both the military and civilian healthcare services. Veterans made many sacrifices during service, for which they were proud of, and in return the same level of loyalty was expected by the military. Yet, common among the findings was the disappointment and frustration towards the military as an organisation, which sometimes was considered as betrayal.

It is well-documented in the literature that transition from military to civilian life is a complex phenomenon itself, which leads to major changes in individuals' lives (Arkenford & FiMT, 2017; Ashcroft, 2014; Copeland et al., 2011; Cox, Grand-Clement, Galai, Flint, & Hall, 2018; Docherty-Hughes et al., 2019; FiMT, 2013; The British Army, 2019). Indeed, transition to civilian life was considered a complex process for veterans, not only due to the numerous

practical changes in life, but also because it requires to develop a new sense of identity, which will help navigate civilian life successfully. It can be overwhelming, especially for veterans who need additional support due to ill physical or mental health. After military discharge, the ambiguity and complexity of civilian life, including daily life, employment, or use of healthcare services, was viewed as a new, unknown reality, which was difficult to manage. During this period, armed forces charities were the main point of contact, which offered tangible and intangible support along with multiple opportunities to socialise with fellow veterans. Maladaptive coping strategies, including alcohol misuse, self-harm and suicidal thoughts, were employed, which in turn led to aggressive behaviours towards others and negatively affected personal and professional relationships. Common among the findings was the importance of emotional and practical support offered not only by civilian family and friends, but also from fellow veterans (while serving and after leaving the military). The importance of the patience and empathy demonstrated by family, including parents and wives or partners was a key element among the findings. Similarly, comradeship was equally crucial; the bonds among veterans were viewed as unique, something that made them feel comfortable and able to share thoughts, worries and troubles that would not be understood by civilians. Despite the difficulties and the ongoing challenges, the realisation of the need to be motivated again and find a purpose in life, led to a conscious decision to change negative thought patterns and attitudes that hindered the transition process and self-growth.

3.3 Part 2: Data from the Narrative Life Interview (NLI) study

3.3.1 Method

Narrative analytical approach was used to analyse veterans' stories, aiming to gain an in-depth understanding of veterans' subjective experiences and explore the links between their life experiences, the role of military service in their identity, transition challenges and the impact on their adaptation to civilian life. Storytelling can play a key role in veterans' transition as it allows them to create a coherent story, make sense of their experiences, better understand their own patterns of behaviour and how they got to where they are now (Ahern et al., 2015; Demers, 2011). In turn, this may enhance their efforts to form an identity, by integrating the reconstructed past and imagined future to provide life with some degree of unity and purpose (McAdams & McLean, 2013). A more concise version of the method is presented below. Further details can be found in the respective chapter (section 4.3).

3.3.1.2 Participants

Thirteen British male military veterans took part in this study. Veterans represented a wide range of demographic and military characteristics (Table 5 NLI Participants' Demographics, section 4.3.2). Nine participants still face challenges with their transition to civilian life (identified by self-report) and had an official diagnosis for a mental health problem (e.g., PTSD, depression, anxiety disorder) either during or after leaving the military. Four participants had a smooth transition to civilian life, yet emotionally challenging at times (identified by self-report), and do not suffer from a mental health problem

(never received treatment or an official diagnosis)[10]. Participants were aged between 25 and 68. Seven participants have served in the British Army, three in the Royal Navy and three in the Royal Air Force. None of the participants had any form of therapy during this study[11].

3.3.1.2 Procedure

Opportunity sampling was used during the process of collecting data through VOS and more participants were recruited using snowball sampling. A modification of the Life Story Interview (LSI) by McAdams (2008) was conducted with participants in this study (Appendix 4). Participants split their life stories into meaningful chapters (before joining the military, during military service, and since leaving the service and becoming a veteran) and provided an overview of these, including detailing key events and key individuals within each chapter.

3.3.1.4 Data Analysis

For the purposes of this study Polkinghorne's analytical framework of '*Analysis of Narratives'* will be used (Polkinghorne, 1995). '*Analysis of Narratives'* aims to produce general knowledge from a set of evidence in a collection of stories, without focusing on the unique (or different) aspects of each story. In

[10] Some participants had suffered permanent physical injuries/amputations. We acknowledge ill physical health as a key barrier of transition to civilian life, yet it was not part of the inclusion criteria for this study.

[11] Participants who took part in this study are noted as "PNLI".

particular, '*Analysis of Narratives'*, using inductive analysis will be employed to analyse the current data (i.e., the aim is to develop concepts rather than imposing previous theoretically derived concepts to the data – for further details please see section 2.6.1.2/a-i). It is acknowledged that veterans' stories are subjective and personal yet while reading their narratives multiple times a key concept emerged, which had both a direct and indirect impact on how they made sense of their experiences while narrating. This key concept is '*pride & loss of pride*' and the analysis in this section is focused on exploring it and its impact. This allowed an in-depth understanding of (i) how veterans perceived the emotion of pride or loss of pride while narrating and how this may have affected the process of understanding, interpreting or making sense of life events, relationships and self and in turn (ii) the ways it may have facilitated or impeded the course of their lives and especially their transition to civilian life.

The narratives given to participants were used for data analysis (not the transcripts). Please note that even though the names and places were factual in the narratives handed to the participants, for the purposes of confidentiality and anonymity any identifiable information was changed before the beginning of the data analysis. NVivo 11 software was used for data analysis (QSR International 2016). Discussions with the supervisors about the derived themes ensured that the themes were accurately reflected in the raw data.

3.3.1.5 Prelude to Results: The concept of Pride

Emotions are often defined as complex states of feelings, which arise from events that in some way have relevance for oneself. The type of emotional

response can be shaped by primary appraisals of the potential positive or negative implications for the individual, along with their ability to cope with these events (Leary & Tangney, 2013). *Self-conscious* emotions (e.g., guilt, shame, embarrassment) involve self-reflection and self-evaluation (Tracy & Robins, 2004), while *social* emotions (e.g., love, admiration) require that individuals are aware of both their own mental states and those of the people around them (Krendl & Heatherton, 2016).

Pride occurs in response to success and it can be classified as a *self-conscious* and *social* emotion as it simultaneously focuses on the self and on others (Tracy & Robins, 2007). Pride is an important emotion as it plays a critical role in many domains of psychological functioning [for further reading please refer to: Tracy & Robins (2007b)]. More specifically, individuals who experience *authentic pride*[12] attribute positive outcomes to their own efforts. Feelings of pride reinforce behaviours, such as altruism or achievement and are linked to self-esteem regulation and maintenance. Pride, and *self-conscious* emotions in general, provide immediate and salient feedback on the individuals' social and moral acceptability and their worth as human beings. Apart from enhancing individuals' self-worth, pride can encourage future behaviour that promotes

[12] *Authentic* pride arises from a self-evaluation of 'doing': specific accomplishments focused on the efforts made towards a goal. *Hubristic pride* arises from a self-evaluation of 'being': global beliefs about abilities and strengths (e.g., "*I do everything well*")(Carver, Sinclair, & Johnson, 2010; Tracy & Robins, 2007b).

social status and increases individuals' inclusion within their social group (Mascolo & Fischer, 1995). Through socialisation, individuals can experience pride in response to praise for socially valued achievements, which not only makes them feel good (in general) but feel good about themselves (specifically). In turn, the reinforcing properties of pride can motivate individuals to seek future achievements and develop an identity that coheres with social norms. This can lead to social acceptance and a sense of increased social status [for further reading please refer to: Tracy, Shariff, & Cheng (2010)].

On the other hand, shame (i.e., the loss of pride) is a powerful self-conscious emotion, which can interfere with individuals' healthy psychological functioning; it is commonly defined as an intense negative emotion associated with the perception of devaluation of the self or a sense of worthlessness and powerlessness (Tangney & Dearing, 2002). Shame is considered among the emotions that are more difficult to regulate, since the focus of the evaluation is on the self or identity (Schalkwijk et al., 2016). Experiences of shame can be painful and could be conceptually related to low levels of self-esteem. In turn, low levels of self-esteem could increase individuals' vulnerability to experience negative emotional states (Velotti et al., 2017). In addition, shame can provoke antisocial behaviours and aggression, which can be viewed as emotion regulation or coping strategies in response to ego threats (Elison et al., 2014). Indeed, the way in which individuals either cope with or defend against shame can have important implications (Elison et al., 2006), including different

shame-coping styles, such as attack self, withdrawal, attack other and avoidance (Nathanson, 1992).

3.3.2 Results

Three master narratives were identified while reading veterans' stories: narratives about the need for pride, narratives of the importance of pride, and narratives on the loss of pride. These master narratives and their respective sub-narratives are presented below (Table 4).

Table 4 Themes Chapter 3/Part 2

Master Narratives	Sub-narratives
Narratives on the need for pride	*(i) Lack of connectedness* *(ii) Looking for inner fulfilment* *(iii) Searching for the inner self*
Narratives on the importance of pride	*(i) Military Service: A meaningful & purposeful occupation* *(ii) Maintaining the balance* *(iii) Military as a family* *(iv) Personal meaning*
Narratives on the loss of pride	*(i) Feeling betrayed* *(ii) Normal becomes alien* *(iii) Loss of identity* *(iv) Feeling alone*

3.3.2.1 Narratives on the need for pride

(i) Lack of connectedness

For most veterans who took part in this study, youth was a challenging time, including poor parenting, lack of emotional and practical support and emotional or physical abuse. When narrating this period of their lives, they highlighted the lack of connectedness with others along with a lack of a deeper connection to themselves that left them feeling empty and isolated while they were growing up.

PNLI4: *"My childhood doesn't really involve good moments […] I still blame myself, for my dad and mum splitting up when I was little […] I had to live with my stepfather. I didn't get on with my step-father, he was a bully. He used to bully me […] One day, two women walked into the house, start beating my mum up. They were my stepfather's wife and daughter. And I saw that, my mum was crying, and later I went upstairs, and she had cut her wrists, blood was everywhere... I had never seen anything like that before…"*

Emotional abuse was highlighted among the narratives as a direct or indirect barrier, which hindered self-growth and independence over the years. Participants' dreams and aspirations could not be shared with important figures in their lives (i.e. parents), due to the lack of parental warmth and affection. For other participants, life was even more complicated, as they had lost their parents at a young age and had to grow up in residential institutes and rely on social services. Feelings of helplessness, anger or bitterness were apparent among narratives. Yet while narrating and reflecting on these

memories, it was acknowledged that at some point in life they managed to use these negative experiences to their benefit and become more resilient; something that was also proven useful in their later career in the military.

PNLI2: "…my mother died when I was 6. I was one of 7 children so we were put into an orphanage […] There was physical abuse and I found out later that there was sexual abuse as well […] I had come out with the feeling that it hadn't done me any harm… It skewed my thinking because I'm very black and white. That carried on till my naval career which is good because I needed that in the Navy. You needed to be black and white in the Navy".

PNLI3: *"They* [parents] *stopped my dream, for an arranged marriage and that was extreme. They stopped me from graduating and being a lawyer… I cried […] I felt I didn't have to listen to my parents anymore and I could be myself as a man. It was time to get my independency because I was already past 21…"*

The lack of connectedness and purpose in life along with maladaptive coping skills and aspirations led them to seek out artificial methods of coping with psychological or physiological pain. Substance abuse, including alcohol and drugs, and at the same time mixing with the wrong crowd, were easy solutions to relieve stress or anger and avoid facing problems and responsibilities.

PNLI6: *"I used to go out drinking a lot... I used to go drinking, get tattooed and do whatever else".*

PNLI8: *"What it was, I was a troubled kid. I was always in trouble with the Police..."*

The feeling of lack of connectedness was also strong among veterans' narratives who did not have a challenging life as teenagers, for example, growing up in a healthy family environment, having caring parents and educational opportunities. Despite this, there was a lack of happiness and inner fulfilment, which became a constant need to grasp exciting opportunities, usually focused around non-academic activities, such as sport (at a younger age), or jobs that would offer a more creative and flexible career (during young adulthood).

PNLI9: "*I had a good upbringing, very lucky […] I enjoyed school, had lots of friends […] I was 22 years old and just sat in an office, typing on a computer. I thought I need to go and do something more interesting […] Even when I went to Uni and stuff like that, it was always in the back of my head* [joining the Navy] *that I think that's what I want to do when I leave, and then I did".*

These thoughts led to the realisation that the 'traditional life route' was not the way that would offer them the excitement they were looking for. On the contrary, the need to identify a new path in life was highlighted; a path, which would become an opportunity to find a new powerful purpose in life and discover who they are through meaningful connections with self and others.

(ii) Looking for inner fulfilment

Different life circumstances led veterans to join the military, but as described in the previous sub-narrative, the idea that military service would be a unique opportunity to escape, become independent and live an unconventional life, was common among the narratives. The need to 'belong' and be part of a

group with common values and purpose was another key element linked with military service, which is promoted as a family orientated environment.

PNLI7: *"…I wanted to be part of a group […] I signed up for the full 22 years and I was, I was game for it, you know as a kid, I suppose as well in the society that we live in, we are fed a romantic notion of joining the military, travelling the world, being a hero, doing these things and, you know, living this Hollywood lifestyle…"*

Serving in the military was considered a great career and life opportunity; it would promote personal growth, self-improvement and development of self-discipline, while at the same time it would offer an exciting lifestyle full of adventures.

PNLI1: "I *knew I had to get a job and the Army was an attractive idea for me back then […] When I joined the army, I was aiming high and I wanted to get hands-on experience and use all the skills I have gained during my training in the battlefield."*

At the same time, participants explained that military was not perceived as just an exciting job, but rather something that is bigger, a higher purpose that would allow them to become proud of themselves, support, offer and contribute to the wider community.

PNLI3: *"At the beginning being in the Navy wasn't something I thought of. I witnessed the 9/11 incident during a skype lecture in taxation law […] that's how I shaped an opinion about security, international terrorism. What caught*

my eye in the Royal Navy was the idea of security… and of course that I would be in the sea again, so I applied for it".

Overall, participants' perceptions of military service involved an unconventional, yet appealing approach to life and the most straightforward way to achieve their professional goals, maintain an adventurous lifestyle and become independent.

(iii) Searching for the inner self

Transition to civilian life was associated with the loss of the sense of self. For some, this was more intense than for others due to personal circumstances, severity of physical or mental health problems or poor emotional and practical support. The loss of identity along with the loss of purpose, motivation and vision, led to the realisation of how crucial the search of their inner self was in order to re-establish themselves in civilian life. Social support was a key facilitator during this process. Veterans expressed their positive experiences with armed forces charities focusing on the opportunities for communication and engagement with like-minded people who share similar experiences and values.

PNLI4: *"But it wasn't only medication. I feel more confident, but that was down to Combat Stress. If I hadn't been there, then I would still be in a psychiatric hospital. Because all these years I was alone. I don't feel alone anymore..."*

Interacting with fellow-veterans was perceived as an 'enlightenment' that made life seem more manageable, especially those for whom self-esteem was a challenge. The need for inner fulfilment and connectedness became central

in veterans' lives again. Avoidance coping and feelings of isolation and loneliness, which were constantly leading to self-destructive behaviours, were elements that veterans wanted to leave behind. The search of motivation and purpose was associated with their need to make themselves useful, be active, creative and support others in need.

PNLI2: *"I've just done a peer mentoring course at VOS so I can help young lads coming through and say, 'there is a light at the end of the tunnel and it might look like this; I was as bad as you when I started and we can get our lives back on track…".*

The importance of emotional and practical support from families, including parents, wives or partners, was highlighted among the narratives. Feeling understood was crucial in their efforts to deal with worry and uncertainty and re-establish themselves.

PNLI1: *"I didn't know what was happening to me […] I remember taking to my mum and her telling me 'You are not who you used to be anymore'. She knew that this experience had changed me. If it wasn't for my mum, I wouldn't be able to settle down…"*

The patience and empathy demonstrated by their families improved veterans' ability to cope with stressful situations by alleviating the effects of emotional distress.

3.3.2.2 Narratives on the importance of pride

(i) Military Service: A meaningful & purposeful occupation

Reflecting on their military career, veterans concluded that it was not just a career choice but a way of life. Serving in the military was perceived as privilege, regardless of any consequences. Veterans talked about how honoured and passionate they were about all the things they have managed to achieve and all the skills they have developed. The strong sense of duty was highlighted as the mental tool that gave them the confidence to tackle the challenges of military life.

PNLI1: "*I felt I had so much power over many things. I thought I could control everything […] My sense of duty was strong, and I was taking my job very seriously. I was always prepared, for example get ready to do section attacks or going into puddles and swamps. I was aiming high, I wanted to shine but also be there and help others.…"*

Veterans perceived their participation in combat, as one of the most exciting parts of their job. This belief was even more intense among veterans who had served in the army. They highlighted how passionate they were to do what they were trained to do, live by and honour the military values, regardless of the circumstances they would have to encounter.

PNLI11: "*As a soldier being in operations is a real challenge and something that most soldiers enjoy. Although it's dangerous and difficult, it's what you're trained for. So you're actually, all the training you've done, and then you get on operations and you are doing it for real. And the bad times are when we had*

friends get killed or badly hurt…"

Equally important for veterans was the opportunities to assist in various humanitarian relief efforts and development of physical infrastructure, support civilians and offer to the society during their deployments.

PNLI1: "*I was serving a higher goal which was to support civilians in need. I am proud we helped and protect the construction of a local school […] and we even managed to work and mentor Afghan soldiers. These efforts were recognised and praised by higher rank officers […] but actually the real deal for me was seeing the kids going to school*".

These moments were described as significant and were highly regarded; contributing to the greater good and saving lives was what helped them maintain their inner balance after experiencing the horrors of war.

(ii) Maintaining the balance

Deployments and combat experiences were discussed in a positive light yet the significant risks along with the consequences associated with it were key part of veterans' narratives. The majority of veterans who took part in this study suffered from mental health problems (e.g., PTSD, major depression), alcohol addictions, impairment in social functioning and inability to work. Even the minority of participants who had a smoother transition due to personal circumstances (e.g., stronger social networks, being healthy), acknowledged the impact that combat experiences had on them as individuals and the way their views were shaped later in life.

PNLI4: *"I would like my leg back, and I would like to erase some of the horrible memories I've got, but for the friends that I've made, and for other aspects of it, I don't regret it. I don't think there's a point to dwell on the past […] you just kind of think, "It's an experience I've had", and I suppose if I didn't step on that bomb somebody else would have, and I'm lucky the way it happened that I survived. A lot of people don't".*

PNLI1: *"I feel proud for these 6 months in Afghanistan, but this doesn't change the fact that this tour changed me completely as a person. These experiences triggered my PTSD, which I didn't know I suffered from till later in life".*

It is remarkable that regretting joining the military was not discussed from any of the veterans, even the ones who were affected the most and still are affected. Regardless of the sacrifices and consequences, the strong sense of duty and pride was a repeated theme among all narratives, closely linked with veterans' way of life not only while serving in but also when they left the military.

(iii) Military as family

Comradeship was a key element in veterans' narratives not only while serving in the military but also when they returned to civilian life. Comrades were considered a second family with strong, timeless bonds. Veterans could always count on someone for support and understanding, regardless of the time spent apart. While narrating traumatic events experienced in deployments or combat, many veterans focused their attention on moments when their comrades suffered a physical injury or died. Even the ones who had suffered a

physical injury themselves, highlighted that witnessing the suffering or death of their comrades was one of the most challenging experiences, which filled them with anger and sometimes guilt.

PNLI1: *"After only two days in Afghanistan I got informed from a friend that one of our mates had died. He was one of the lads that really looked after me and supported me when I first joined the army. I remember telling him, before his departure, to be careful. Straight away this feeling of anger hit me, I got mad, I was thinking 'Fucking bastards, they're now one nil up', because they took my friend's life".*

PNLI10: "*There had been a big explosion, and we didn't know what quite it was, but when we got back the sergeant major for the company told us it was one of our friends who had been killed […] I think that was quite a horrific experience to deal with, because it was one of my friends. I had spoken to him that morning and now the person has gone"*.

Comradeship buffered the impact of depressive symptoms and emotional distress and helped veterans keep things in perspective, both while serving and after leaving the military. Surrounded by comrades while serving and fellow veterans after leaving the military, reduced the feelings of loneliness and isolation, especially during the challenging periods such as returning from deployments, during rehabilitation and during and after transition to civilian life.

PNLI13: *"I started to look at myself pragmatically, 'how can I deal with this?'.*

One of the ways was I reached out to my military friends, especially guys I've been on tour with who were there, similar situation to me. I had discussions with them and chats about it and that was really beneficial…"

Transition to civilian life was a complex process for many not only because of health issues but also lack of understanding, emotional and practical support from civilian family or friends. Veterans highlighted that being around people who have similar mindsets and share similar values and experiences helped them to draw strength, gain confidence, express themselves more and feel positive about who they are.

PNLI4: *"There were other veterans as well, and some old ones from WWII. I felt good being there because I wasn't the only one being ill; […] we talked with each other, sometimes they cried; they had been through the same things that I've been through as well […] for the first time, I started mixing with people. I felt more comfortable with them because they understood what I was going through… I started finding myself again…"*

PNL10: *"It doesn't mean we're better than anyone else. But I think because of that stuff, we understand…You can go anywhere in the world and meet a veteran, and you can be chatting and just get talking to them as if you're a friend. Whereas you can't do that with a normal civilian".*

The military values embedded in military culture are reflected in veterans' individual behavioural decisions and choices. These values and shared identities are so strong that can bring service members and veterans close

even if they do not know each other, something that appears to be a key difference between military and civilian culture.

(iv) Personal meaning

Veterans discussed how challenging the transition from military to civilian life can become when trying to adapt to the cultural differences. Some made conscious decisions to maintain their 'military identity', considering themselves 'ex-military personnel' or 'veterans'. These are not just titles but represent the values they want to maintain and live by as civilians.

PNLI10: *"I put myself in the category of ex-military, as a veteran. I would say we have a close-knit group, I think, and a very special group of people that have been to Afghanistan and understand. It doesn't mean we're better than anyone else. But I think because of that stuff, we understand…"*

Maintaining a sense of identity helped veterans to be more prepared for transition, manage realistic expectations, and better manage the ambiguity of civilian life. It created a more stable environment, which enabled them to navigate potential practical or emotional challenges.

PNLI2: *"My family still see me as being military […] I will still do things in a military style, so I will clean my shoes in that way for example. My transition was okay because I decided to keep who I was. I am very military".*

For some life was lacking direction and motivation for a long period of time yet there was a crucial moment when they decided to move forward. Overcoming

challenges led to personal development and further self-growth, helping veterans to set new goals, use their transferable skills and progress over time.

PNLI4: *"I think my childhood shaped my life over the years… a lot […] the thing is I have seen aggression and I know how to calm aggression down. But with the job I have now as a bouncer, I am able to use all the negativity and the knowledge I had from when I was little… bullied as a kid, bullied in the Navy… all these helped me to do the job I am doing now".*

Common among the narratives was the importance of making sense of their life experiences and acknowledging the emerging sense of self through this process. Who they were, who they have become and how they can turn this to their advantage was an important realisation made by all veterans.

3.3.2.3 Narratives on the loss of pride

(i) Feeling betrayed

Feelings of helplessness were apparent when veterans were narrating situations that deeply affected and disappointed them. These situations were focused on challenging events that occurred during or after military service and are associated with the military as an organisation. Some veterans talked about cases of emotional or physical abuse, which they had to deal with while serving. Behaviours like these are sometimes 'allowed' or tolerated as the way to build character and toughness. It was difficult not only to cope with these types of situations emotionally, but also deal with them practically, for example, speak about it or report it.

PNLI6: *"There was a friend I served with who was gang-raped by 10 other squaddies. He ended up sleeping in my room for quite a bit… there was a large Court case over it. I myself got hung out of a three-story window by my ankles and hit by a leather pipe […] As soon as I got to the battalion, nothing changed, if anything it got worse the longer we were there [...] there were a lot of issues with bullying, with race […] there wasn't any support whatsoever. I tried to explain my situation when I got there. It didn't really make any difference".*

The greatest disappointment for veterans was not getting the respect and loyalty they deserved after leaving the military. Reflecting on these negative situations produced anger and doubt. Participants argued that their perceptions of the military (as an organisation) were negatively affected by the way they were treated, feeling dissatisfied or even resentful due to the lack of support and guidance during or after their transition. Especially veterans who had served in combat roles, willing to sacrifice their lives and suffered the consequences (i.e., ill mental or physical health), felt 'abandoned' and exposed to the challenges of civilian life.

PNLI5: *"There's all this stuff about loyalty […] I put in my notice a year ago. 'Oh, okay, bye'. There is no loyalty. It's a massive misplaced. You're expected, you're meant to do all this, and realistically you know they don't give a shit […] even guys that have retired, the loyalty is demanded. It is expected one way, but it is never ever reciprocal".*

Feelings of betrayal were a common theme associated with the numerous practical difficulties during resettlement and transition. The lack of both

tangible and intangible support was considered a major barrier during the preparation for transitioning and discussed in a tone of great disappointment.

PNLI1: "*I couldn't deploy anymore due to my injuries and it was a period of time that the military was trying to reduce its numbers so the easy option was for me to be discharged […] The problem was that they robbed my life keeping me in for almost three years […] I felt they mistreated me and I got paid out of the army not even a year's wage, with no further rehabilitation support*".

A discussed in previous sub-narratives, veterans were proud of serving and their aim was to establish themselves and build a career in the military. Ill mental and physical health was for many the end of their military career and that was disheartening per se. The perceived lack of loyalty from the military during challenging times was common among all narratives as something that tainted all the good memories.

(ii) Normal becomes alien

Life changing events, such as permanent physical injuries or development of mental health problems, were a crucial part of veterans' narratives. It was acknowledged that incapability or unwillingness to accept and in turn cope with ill health, had a long-term negative impact on their psychological health and well-being. Military's masculine culture was a key barrier for issues associated with emotional distress or ill mental health and the difficulty of admitting or discussing something related to mental health was highlighted.

PNLI11: "*I was having flashbacks. I was having nightmares and things. I was waking up …but in those days it was like, it was almost like showing weakness. I actually spoke to a medical officer […] and all she said to me, 'oh do you want to see a shrink?' Straightaway I went, no not at all".*

The fact that physical injuries or disabilities were visible helped veterans to accept and adjust to the new life despite the challenges involved. On the other hand, emotional wounds are invisible, thus more difficult to identify the unusual array of symptoms, understand and accept.

NLI10: *"The mental health side was the hardest to deal with. The physical injury, okay, what happened was severe and I lost a lot of blood, but you can see that. You can touch it. People understand. Whereas I think the mental side was harder to deal with, because it's your brain, and you can't explain it".*

Veterans' decision to get professional help depended on their unique experiences and circumstances. However, they acknowledged not making this decision in timely manner but rather when they had reached their limits or were incapable of coping with symptoms anymore.

NLI2: *"I left the Navy in 1997 […] I hated going to bed because I knew that I would wake up with the nightmares. That's why I went to see the Doctor. I wasn't sleeping at all and I was sleeping a few hours a night if I was lucky. This was in 2000. The doctor said he thought I had PTSD. […] I had all the classic* symptoms*, the flashbacks, the dreams, excessive drinking, the aggressiveness".*

Interestingly, even in cases where veterans had an official diagnosis, it was not enough to understand the nature of their problem and effectively cope with it.

PNLI3: *"All these years I really didn't try to ask for help. The problem was that they say to you that you have PTSD and that's it. They don't explain or educate you about PTSD, how to cope and live with it. I didn't know, I thought all that was normal. It was only when I decided to make a self-referral, and do therapy, that I actually got PTSD education".*

The lack of knowledge, tailored support and correct information regarding ill mental health, led to a vicious circle of ineffective treatments and constant deterioration of health.

(iii) Loss of identity

Losing the inner fulfilment and connectedness with themselves and others became a common theme while narrating the challenges faced during transition. What they had achieved and how they perceived themselves while serving had now become a memory they were proud of. The cultural differences between civilian and military life led to an identity crisis along with low self-esteem, a loss of self-confidence, isolation and loneliness. Veterans felt unprepared to undertake responsibilities, as they were unmotivated or unable to set new goals on what they wanted to achieve in the short- and long-term.

PNLI1: *"They made me into something I wasn't and now I feel I have no identity. I feel lost between my military and civilian identity".*

PNLI3: *"I felt my pride was misplaced, I felt like I had failed, like I am not doing enough. I wanted to prove these guys that I can still do military function. So, my identity was still like a military identity and it was really challenging".*

At this point the feeling of helplessness was common among the narratives. Losing the sense of identity caused disorientation and led veterans to employ maladaptive coping strategies in order to escape reality. Some veterans admitted that struggling with ill mental health led to long-term issues, such as loss of productivity and ability to make decisions and undertake responsibilities. Despite acknowledging that alcohol was not a permanent solution, drinking heavily was an escape route to avoid facing personal or work-related issues.

PNLI2: *"I had always drunk but I didn't realise how much I had drunk. I don't get hangovers at all. It used to be the case of taking a top off a bottle, I never put it back again because I knew I would finish it. The flashbacks were the reason I was drinking. Drinking that amount would make me comatose…I hated going to bed because I knew that I would wake up with the nightmares".*

PNLI9: *"Drinking, always drinking […] that first year, I was drinking way too much because I was just miserable".*

Narratives of rigidity and inability to make sense of who they were and how to be a civilian led to aggressive behaviours towards others and themselves, including suicidal thoughts and suicide attempts. This did not only have a negative impact on veterans' well-being, but affected personal and

professional relationships, leading to constant arguments and distance among them and other people.

PNLI1: *"I became very violent and that costed me many friends. I was so aggressive that even my own family was scared of what I had become… I couldn't understand why I was feeling so tired […] I didn't have the power, this self-achievement feeling I used to have when I was serving in Afghan".*

(iv) Feeling alone

The loss of identity and purpose after transition made participants' lives more complex and unmanageable. Participants who were married or in a relationship argued that by avoiding communication and honest conversations with their spouse/partner led to deterioration of the situation (e.g., misunderstandings and constant arguments) and in some cases even ruined the marriage/relationship.

PNLI13: *"I think I internalised a lot. It made me a difficult partner. I think we're both quite bad and it's almost the English way is we don't like to talk about things like this. That is a criticism of us as a couple. We didn't really talk about stuff which bothered us. I think that was one of the reasons why we broke up".*

Lack of or poor social support was also identified as a key barrier, especially during challenging times. In particular, many single veterans stated that this hindered their transition to civilian life and increased emotional vulnerability.

PNLI10: *"So, I didn't really have much of a support network in that sense* [family/friends]*, and there was nobody I could speak to about it. I found it really*

tough, and I understood what guys were talking about now when they have problems leaving the military".

Overall, different personal circumstances led participants to isolate themselves and stop communicating distressing thoughts and feelings with significant others. As a result, feelings of loneliness were increased and potential key sources of support, such as spouses/partners, family or friends were sometimes neglected by veterans.

3.3.3 Discussion

In this section the impact of pride or lack of pride in veterans' lives was explored. The virtue of pride was a common theme among all narratives and it was closely associated with all stages and aspects of veterans' lives. In many cases, it appeared to be an indirect yet key protective factor, with multiple benefits as an outcome. On the contrary, the lack of pride was related to stages in life when veterans were challenged emotionally, felt helpless, had to cope with ill health or deal with pressure and stress. Pride and loss of pride are linked with veterans' life transitions, both from civilian to the military and military to civilian, in a circular narrative. Findings indicate that pride tends to follow a cyclical pattern from looking for pride at a young age, to gaining pride while serving in the military, to losing pride upon leaving the military and finally seeking pride in civilian life (Figure 2).

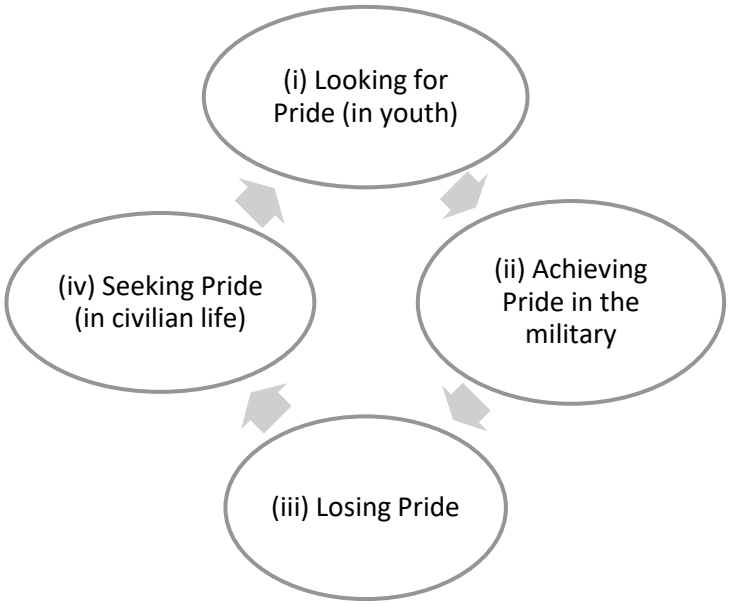


Figure 2 The cyclical pattern of pride

(i) in youth veterans needed to do something to give them the drive to keep going and constantly motivate them, (ii) joining the military was indeed the stage in life that they were proud of and the one that gave them a higher purpose, (iii) certain circumstances while serving and transitioning to civilian life were related to the loss of pride, which affected some veterans more than others and finally (iv) the acknowledgement that the only way to redefine their purpose in life, find deep meaning and fulfilment was by re-establishing their pride in civilian life.

Narratives on the need of pride indicate the compelling desire and passion veterans had as young individuals to escape from 'their reality', explore their options, find adventure and live an unconventional life. Military was perceived as the 'perfect option', a unique opportunity to build a strong and meaningful career for which they would be proud of. Transition to civilian life was

associated with the loss of this pride and the need to re-shape their identity and re-establish themselves in civilian society. Key facilitators were the emotional and practical support from civilian family and comrades/fellow-veterans. High levels of understanding and empathy allowed veterans to feel comfortable with themselves and civilian norms and culture.

Life narratives tend to focus on the most significant events, either positive or negative, as these are the experiences that shaped individuals over time and it is crucial to make sense of (Adler et al., 2016; Mcadams et al., 2001). Indeed, narratives on the importance of pride show its importance and buffering effect on all aspects of veterans' lives, including positive and negative experiences. The emotions of authentic pride played a significant role in finding purpose and developing a strong sense of identity (Dyson, 2006). Pride was a key element of military service, which was considered by veterans a meaningful career that allowed them to develop lifelong learning skills and achieve self-growth. Pride also acted as a protective factor against the challenging times and negative consequences of military service, including traumatic experiences, physical injuries or development of mental health problems.

Military ways of being become deeply embedded to individuals and can continue to influence, in complex ways, their behaviour and identity long after their transition to civilian life (Caddick et al., 2018). Narratives on the loss of pride reflect the negative impact of the loss of the sense of self and purpose in life. Veterans' pride in the military service was tainted by the perceived lack of loyalty, which created a climate for betrayal. Lack of any type of tailored

support and psychoeducation regarding mental health problems and ways to understand and manage the symptoms, were key barrier that hindered the transition to civilian life along with the efforts of making sense of self in the new reality (i.e., civilian life). Individuals form an identity by integrating their life experiences into an internalised, evolving story of the self, something that in turn can provide them with a sense of unity and purpose in life (Hammack et al., 2008; McAdams, 2011). Indeed, findings suggest that the loss of identity and the perceived sense of lack of power, can lead to a vicious circle of maladaptive coping, aggressive behaviour towards self and others and unhealthy and unproductive personal and professional relationships. Finding and understanding the inner self was closely linked with the re-establishment of pride in the new reality and the path to try and find again the lost (yet needed) fulfilment and connectedness with self and others.

3.4 Conclusion

The aim of this chapter was to develop a more sophisticated and holistic understanding of British male veterans' subjective experiences regarding the practical and emotional challenges faced during transition to civilian life and identify potential factors that may have facilitated or hindered transition according to veterans' perspectives. The chapter was separated into two parts. Inductive thematic analysis was used in the first part, allowing the identification of the key themes of how participants perceive their transition to civilian life and in turn gaining a better understanding of their perspectives and subjective experiences. Polkinghorne's analytical framework of '*Analysis*

of Narratives' was used on the second part of this study, allowing an in-depth understanding of participants' overall life story, which construct their own unique reality and sense of self. Using two different analytical frameworks to explore life experiences before, during and after military service, shed a light into the different aspects of the complex process of life transitions. The findings of this Chapter will be combined and discussed in Chapter 7, in light of what is already known about the issues facing the veteran community, along with limitations and recommendations for future research and practice.

Chapter 4: Storytelling as an Intervention - The Narrative Life Interview

4.1 Introduction

The narrative approach enables individuals to present their experiences, thoughts, and feelings as a story and in turn allows the researcher to obtain a deeper understanding of participants' lives and gain access to the social and psychological outcomes of participants' traumatic experiences (Murray, 2008). A positive aspect of narrative approach is that it can be an empowering experience as a process. It can be 'therapeutic' in its own right, as it allows traumatised individuals to view their experiences as separate from themselves, making it easier to recognise, understand and protest its influence establishing a rapport between author and listener/reader (Riessman, 1993; White & Epston, 1990).

4.2 Research Aims

i) The Narrative Life Interview

The first purpose of this study is to evaluate the NLI, as an interview technique by exploring the overall impact of the process on participants. For this purpose, the qualitative data from follow-up interviews (i.e., participants' feedback) and the scores from the psychometric measures will be used.

ii) The Narrative Construction of Reality

This section is a continuation of Chapter 3 and will help towards the development of the HMoMT. The aim is to shape a more comprehensive

opinion on how past life experiences (e.g., childhood) and military experiences could facilitate or impede veterans' transition and their efforts to re-shape an identity. The life stories of two mentally traumatised British military veterans will be explored; the focus will be on individual experiences to explore how they affected the formation of a clear or confused sense of identity and in turn facilitated or hindered the reintegration to civilian life. The main question to be discussed through the lens of McAdams' Narrative Identity Framework (McAdams et al., 2001; McAdams & McLean, 2013) is why the one individual managed to better cope with their traumatic experiences and have a smoother transition to civilian life when the other did not and as a consequence his psychological well-being and transition to civilian life was negatively affected.

4.3 Method: The Narrative Life Interview

4.3.1 Study Design: NLI

NLI was used in this study. The first session is the main interview which follows the core structure of LSI. This provides an insight into complex issues that mentally traumatised veterans face, the meanings they give to their experiences and the how these influenced the way the re-shaped their identity. The second interview after a week, allows the individual to reflect on their written story, the feelings and thoughts they have shared. This reflection can be critical in order to better understand the ways in which narratives help people make sense of their traumatic experiences and grow through them. Two psychometric measures were used to better monitor potential changes after the intervention along with the follow-up interviews.

4.3.2 Participants

Thirteen individuals living in the UK were interviewed. Participants were all male British military veterans. The inclusion criteria:

- Group 1 (N = 9): Veterans who still face challenges with their transition to civilian life (identified by self-report) and had an official diagnosis for a mental health problem (e.g., PTSD, depression, anxiety disorder) either during or after leaving the military[13].
- Group 2 (N = 4): Veterans who had a smooth transition to civilian life, yet emotionally challenging at times (identified by self-report), and do not suffer from a mental health problem (never received treatment or an official diagnosis).

Participants were aged between 25 and 68. Seven participants have served in the British Army, three in the Royal Navy and three in the Royal Air Force. None of the participants had any form of therapy during this study. Please see Table 5 NLI Participants' Demographics for participant characteristics in detail[14].

[13] Some participants had suffered permanent physical injuries/amputations. We acknowledge ill physical health as a key barrier of transition to civilian life, yet it was not part of the inclusion criteria for this study.

[14] Participants who took part in this study are noted as "PNLI".

Table 5 NLI Participants' Demographics

Code Number	Age	Military Experience Military Service	Marital Status	Education	Profession	Physical Injury	Mental Health diagnosis
P1	27	7 years Army	Single	Level 3 Electrician	Not employed	No	Yes (PTSD)
P2	61	22 years Royal Navy	Married	University educated	Retired	Yes	Yes (PTSD)
P3	39	8 years Royal Navy	Single	University educated	Full-time university student	Yes	Yes (PTSD, depression)
P4	55	4 years 11 months Royal Navy	Married	Secondary school	Casual Worker	No	Yes (PTSD, Borderline personality disorder)
P5 (Group 2)	37	10 years Royal Air Force	Married	A-Levels	Full-time IT sector	No	No
P6	25	3 years Army	In a relationship	Secondary school	Full-time Chef	No	Yes (Depression)
P7	33	4 years Army	In a relationship	A-levels	Full-time Chef	Yes	Yes (Anxiety Disorder & panic attacks)
P8	45	25 years Army	Married	GCSE	Full-time Personal Trainer	No	Yes (PTSD)
P9 (Group 2)	39	13.5 years Royal Air Force	Married	University educated	Full-time project manager	Yes	No
P10	27	4.5 years Army	Cohabiting	Secondary School	Part-time customer service	Yes	Yes (Depression)
P11 (Group 2)	68	35 years Army	Married	University educated (MSc)	Full-time Company Director	Yes	No
P12 (Group 2)	44	17 years Royal Air Force	Married	University educated (MSc)	Full-time Consultant	No	No
P13	42	15 years Army	Divorced	University educated	Full-time university student	No	Yes (Anxiety disorder)

4.3.3 Interview protocol

4.3.3.1 Interview Protocol for 1st set of Narrative Life Interviews

A modification of The LSI by McAdams (2008) was conducted with participants in this study. Most of the questions asked followed the structure of the LSI starting from the earliest to the most recent significant experience participants had undergone. Participants split their life stories into meaningful chapters and provided an overview of these, including detailing key events and key individuals within each chapter. They were given the option to use the following 3 chapters: before joining the military, during military service, and since leaving the service and becoming a veteran. The next part focused on six key scenes in their life story to explain how these events have affected them or changed something about them. They included providing detailed descriptions of: a positive and negative childhood memory (before the military); a high point, low point, turning point, and a vivid adult memory (during and after military service) (McAdams, 2008). A new key scene was introduced for the purpose of the current study: the most traumatic experience undergone during their military service. Participants were asked to relate traumatic events in detail with particular emphasis on their past and current emotional states elicited by talking about these events. Some of principles of questioning used in Narrative Exposure Therapy (NET) were applied to this question regarding traumatic experiences. The other two key scenes 'wisdom event and religious, spiritual or mystical experiences' were removed from the interview protocol. Section D 'Challenges' (Life challenge; Health; Loss) and Section E 'Personal Ideology' (religious/ethical values;

political/social values; the single most important value in human living) from the McAdams LSI was almost fully incorporated in the study. Section C 'Future Script' was modified as a two-part question focusing on participants' descriptions of their dreams, hopes, and plans for the future and the ways they will achieve them. The interview ended with Section G 'Reflection' where the researcher thanked participants for their contribution in the research, allowing time for reflection or for additional comments. Participants were asked to discuss their feelings during and after the interview and how it affected them. A copy of the interview protocol can be found in Appendix 4.

4.3.3.2 Interview Protocol for follow-up Interviews

Follow-up questions centred on (a) receiving feedback from participants regarding the process overall (e.g., if they have benefited from the process) and (b) discuss their story and allow time to make the appropriate changes or further additions. A copy of the interview protocol can be found in Appendix 4.

4.3.4 Psychometric Measures

Participants were assessed on psychometric measures (HADS and PCL-5) at two time points. Time point 1 was before the first set of interviews and time point 2 was after one week of the follow-up interviews to monitor potential changes in symptoms of depression, anxiety and PTSD post-intervention and assess the efficacy of the intervention. It is acknowledged that this is a small and non-representative sample and thus the purpose of the psychological measures was not to be used independently, but rather in conjunction with

the qualitative data from the follow-up interviews. The validity and reliability of these measures were discussed in Section 2.4.3.

4.3.5 Procedure

Opportunity sampling was used during the process of recruiting participants. The researcher approached charities for veterans to inform them about the research and secure future collaborations. The gatekeeper of VOS gave permission to the researcher to advertise the research and recruit participants. More participants (who were not part of VOS) were recruited using snowball sampling.

Thirteen interviews were conducted in total. Three interviews were conducted at the VOS premises in a seminar room booked in advance by the gatekeeper. Seven interviews were conducted at The University of Nottingham in a seminar room booked in advance by the researcher, and three interviews were conducted via telephone. Ten follow-up interviews were conducted face-to-face or via telephone.

During the interviews:

The researcher communicated the interview questions ahead of time to participants, along with a general introduction about the study. Participants were requested to read the information sheet and the consent form, and time was allowed for the participants to ask relevant questions about the study. Issues of anonymity and confidentiality were explained to them, as were the reasons for using a Dictaphone or ACR (a call recorder app for phone interviews) to record the interview (in order to enable a detailed transcription

to be made). Participants were informed that they could withdraw from the study at any point without further consequences. Participants were requested to sign the consent form before the beginning of the interview. Their name was replaced by a code number and any names mentioned in the interview have been changed. However, names and places were factual in the story handed to the participants. The researcher transcribed the interview in order to produce a detail narrative of the participant's story (in a form of a biography). The researcher did not add any extra details, or embellish the narrative in any way (e.g., slang words), apart from removing speech errors, filler words, repetitions, and moving parts of the story in chronological order where necessary. Notes were kept in case clarifications were necessary. When the narrative was ready it was sent via an e-mail to the participants to read and encourage them to make changes or additions in their story if needed. After one week the follow-up interviews were arranged at a convenient day and time for the participants. The procedure for the follow-up interviews was the same as in the first set of interviews.

The interviews were conducted between December 2017 and March 2018. Interviews were carried out in English and transcribed by the researcher. They varied in length from approximately 1 hour to 5 hours for the first set of interviews, as some participants were willing to share many of their life experiences and provide details, and 15 minutes to 30 minutes for the follow-up interviews.

4.3.6 Narrative Analysis

Narrative Analysis based on McAdams' guidelines (McAdams, 2008; McAdams et al., 2001) was used to obtain a deeper understanding of participants' pre- and post-military experiences. More specifically, the data analysis follows McAdams framework for understanding redemption sequences (McAdams, 1999), contamination sequences (McAdams, 1998) and Narrative Identity (McAdams, 1996; McAdams, 1994). The purpose of this analysis is to identify these two distinctive narrative strategies (redemption/contamination) that participants employed while narrating their life stories and made narrative sense of their personal experiences. Two stories were chosen for analysis. A summary of participants' stories is provided and then examples of key points in participants' lives will be presented and analysed according to this framework. This will lead to an enhanced understanding of the way participants' lives evolved and how their life experiences shaped their identity and affected (i.e., aided or hindered) their transition to civilian life. The full narrative stories given to participants (not the transcripts) were analysed using NVivo 11 software (QSR International, 2016).

4.4 Part 1: The Narrative Life Interview

4.4.1 Results: Follow-up interviews

All participants argued that they felt positive sharing their pre- and post-military experiences, acknowledging the 'therapeutic' benefits of NLI (different from clinical model approaches). Overall, NLI was considered very useful, with no further recommendations on the way it is conducted. There was no

negative feedback regarding the process. The data analysis indicated four key elements (Table 6):

Table 6 Themes Chapter 4/Part 1

Key elements of NLI
(i) Structure
(ii) Sharing Positive & Negative Experiences
(iii) Opportunity for Self-Reflection
(iv) Written Copy of the Narrative

(i) Structure

Structure was reported as the core element of NLI. Conducting the interviews in the form of a timeline (starting by discussing their childhood and finishing with their present situation and future plans), enabled participants to put their stories in order, revisit memories, remember valuable moments and successfully link everything together by making sense of their experiences.

PNLI3: *"In a scale of 1 to 10, 10... I think every part was useful, because you section it from the beginning, it was like a timeline and it was easy for me, it was structured, and I liked that. It is easier to see how things happen before you come to the conclusion. I wouldn't say I found the interview stressful; I would say it was like fighting with myself […] it is like a battle, but I think I won in the end…"*

The timeline structure helped participants to feel more comfortable and relaxed during the interview, especially when discussing negative or traumatic past life experiences, but also reflect when reading their stories. Receiving their story written in an organised and concise manner, including all the positive and negative events, proved beneficial in reducing the risk of emotional distress.

(ii) Sharing Positive & Negative Experiences

Having the opportunity to share important and positive life experiences was deeply appreciated by participants as it increased the therapeutic benefits and facilitated the interview experience and self-reflection overall.

PNLI5: "…It is nice to talk about yourself I guess […] The trickiest part is talking about things that maybe British people don't say as much… It is a good process and I liked it… for myself I found it very interesting to sort of go back and have a look at and reprocess some of the things that…It is funny how we see things…"

Reminiscing positive memories created a balance during and after the interviews, which reduced potential emotional stress and became an opportunity for participants to re-focus on the bright side of their lives.

PNLI7: "*It is something that I can use, to put it in context sometimes. So, say if I am starting to feel down, you know, I can look back at it* [written story] *and go 'well, I've actually done this, I've done that… and I had to go through worse already so… it's a good wat to keep yourself checked…"*

The nature of the interview helped participants to see their life experiences and negative feelings from a different point of view and find ways to process them in a more productive way.

(iii) Opportunity for Self-Reflection

A positive outcome of having time to read and process their narratives, allowed participants to reflect on their life course holistically, but also identify patterns of behaviour, observe unconscious thoughts and unrealised feelings.

PNLI13: *"…It made me think about it a lot and I found it beneficial first of all, it's nice to see things put in a logical order, in paper, in a way you can understand… it's very unusual to have your own words read back to you and I can almost see my speaking style and certain idiosyncrasies I have… a bit annoying, but it's nice to see it and it really was amazing I could read my own story […] the title is quite amazing really 'My Story' and it is really interesting to see right from when I was a teenager almost up to the present day…"*

This process allowed participants to look things from a new perspective, by putting their life experiences in order. It was an opportunity to reconsider the way life challenges were managed, visualise a better future or new ways they could succeed things and appreciate the value of self-reflection.

(iv) Written Copy of the Narrative

Obtaining a written copy of the narrative, was reported as a unique element of NLI, which allow time for self-reflection, further discuss and the freedom to amend (e.g., add, remove, expand) parts of the story to best represent who they are.

PNLI4: *"I always wanted to write a manuscript […] but seeing it on paper is such a relief. All the problems, all the big times…I can now see it on paper… now it is gonna help other people… it's fantastic, brilliant. I always wanted that, and it helped me out a lot […] it took so much stress from me… All the things I had inside me now they are on paper, people can actually see me for who I am, what I've been through and who I am now".*

Having a written copy was also considered an alternative and creative way to also benefit and inspire others. Participants argued that they would be more than happy to share or publish their story (e.g., in relevant magazines/websites) aiming to raise awareness of the and positively impact other veterans or their families, who still struggle with the transition from military to civilian life.

4.4.2 Results: Psychometric Measures

Participants were assessed on psychometric measures (HADS and PCL-5) at two time points. Time point 1 was before the first set of interviews and time point 2 (one week after) on the follow-up interviews to monitor potential changes in symptoms of depression, anxiety and PTSD post-intervention and assess the efficacy of the intervention. It is acknowledged that this is a small and non-representative sample and thus the purpose of the psychological measures was not to be used independently, but rather in conjunction with the qualitative data from the follow-up interviews. Participants who did not take part in the follow-up interviews and did not complete the questionnaires were not included in the analysis. Initially, a Shapiro-Wilk test was conducted

in SPSS (IBM SPSS, 2016) and results indicated a non-significant departure from normality (p > .05); more specifically, for depression pre: W(10) = 0.94, *p* = 0.62, post: W(10) = 0.94, *p* = 0.55, for anxiety pre: W(10) = 0.93, *p* = 0.50, post: W(10) = 0.92, *p* = 0.43 and PTSD pre: W(10) = 0.88, *p* = 0.13, post: W(10) = 0.90, *p* = 0.24.

A paired-sample t-test was then conducted in SPSS (IBM SPSS, 2016) to compare the pre- and post-test scores of depression, anxiety and PTSD and better monitor potential changes (Table 7).

Table 7 T-Test NLI

	Pre-test			Post-test		Paired Samples Test		
	N	Mean	Std. Deviation	Mean	Std. Deviation	t	df	Sig. (2-tailed)
HADS D	10	7.70	4.900	6.00	3.801	2.847	9	.019
HADS A	10	11.00	4.595	9.70	4.029	4.993	9	.001
PCL-5	10	39.70	21.489	33.60	19.631	6.434	9	.000

The results from (i) the depression pre-test (*M* = 7.70, *SD* = 4.90) and post-test (*M* = 6.00, *SD* = 3.80), (ii) anxiety pre-test (*M* = 11.0, *SD* = 4.59) and post-test (*M* = 9.70, *SD* = 4.02) and (iii) PTSD pre-test (*M* = 39.7, *SD* = 21.4) and post-test (*M* = 33.6, *SD* = 19.6), indicate that storytelling and the opportunity to share their life stories was indeed beneficial, (i) *t* (9) = 2.84, *p* = 0.019, (ii) *t* (9) = 4.99, *p* = 0.001 and (iii) *t* (9) = 6.43, *p* = 0.000, respectively.

These results are in line with the qualitative data from the follow-up interviews, indicating that the NLI process, even though it is an interview technique and not therapy, had an overall positive impact by enhancing participants' psychological well-being, with some short-term benefits achieved through the process of narrating and sharing their life experiences in a safe environment. Of note here, even though participants did not attend any other form of therapy when the interview was conducted, this positive change can be a combination of factors, unique to each participant. Further evaluation (e.g., in one, three, six and twelve months) is necessary to monitor and establish the long-term benefits of NLI.

4.5 Discussion

The NLI is a type of interview technique, which combines the key principles of McAdams' LSI and NET. NLI as a research tool goes beyond collecting rich qualitative data, aiming to also allow participants to experience any 'therapeutic' benefits involved during the process (different from clinical model approaches). To understand the unique perspective of an individual and understand their experiences in life, it is important to let their voices be heard and to speak for and about themselves and their relations to others (McAdams, 2001). Current findings indicate that the structured nature of the interview and the freedom to share positive and not only negative/traumatic experiences were identified as key benefits of NLI. The format of LSI allows researchers to look at participant's life as a whole, while carrying out an in-depth interview in the form of a timeline, covering positive and negative memories or events and

explore major life issues, such as family changes, health, life challenges or spirituality, in all stages of life (McAdams, 2008). Similarly, in NET the patient will construct their life narrative in a chronological order with a focus not only on the traumatic experiences but also the positive ones (Schauer et al., 2011). Of note here, life stories are not always organised and incoherence can prevail in the narratives of individuals who suffer from mental illness due to their inability to bring sense to this experience (Murray, 2008b). When an individual is framing their life story solely around the traumatic experiences, it can lead to a feeling of persistent trauma and distress. The structured order in combination with the narration of positive events facilitates the transformation of the fragmented narrative of traumatic experiences into a coherent one (Crossley, 2000a) and influences individuals' perceptions of their experiences and well-being.

NLI, similarly to NET, does not restrict participants in choosing one particular positive or negative/traumatic event, but rather allows them to engage in narrating their whole story, reflect on their or others' behaviours/attitudes, embrace the trauma and in turn develop a feeling of personal identity. Results suggest that the opportunity to re-tell a story, revisit memories, connect events and emotions, facilitated the flow of the interview, but also benefited individuals allowing time for new realisations and self-reflection while and after narrating their story. These findings are in line with the literature suggesting that developing a biographical narrative account is a kind of psychological intervention per se (Rosenthal, 2003) as it helps narrators to understand, contextualise and map their experiences and emotions. NLI is not

therapy, rather an interview technique which could have some kind of 'therapeutic benefits', by giving the opportunity to participants to better understand themselves, evaluate their negative life experiences and encourage themselves from the positive ones. Each individual experience this process in a different way and depending on their unique experiences and current life situation, they can be benefited in multiple different ways. The way individuals frame the experiences that shape their lives, helps them create an ongoing meaning for these events, which in turn can lead to progression and inner growth (Fivush et al., 2017). Findings also suggest that self-reflection was one of the key benefits of the NLI process, as it facilitated participants to comprehend and integrate behavioural and emotional patterns that emerged during narration but also while reading their story. Obtaining a copy of their story was a significant contribution and was highlighted as another key benefit of NLI. It was considered to have multiple benefits not only on a personal level but a way to let other people know them better and by sharing it to help and inspire other veterans or their families. Atkinson (2001) argued that during a life story interview, the interviewee is the narrator of their story and the interviewer is a guide, without being in control of the story, but rather collaborate to construct a story that the narrator is pleased with. The point is to give the opportunity to the participants to tell their story and establish a safe environment, allowing them to open up and achieve honesty and coherence in the story. Indeed, and self-reflection along with collaboration with the researcher were reported as key elements multiple times during the NLI process (i) during the first interview while participants were narrating their

story and the researcher was asking questions to provoke further insights or elaborations from them, (ii) between the interviews, when participants had time to read their story written by the researcher, in their own time and especially during the second interview, when participants had the time to interact with the researcher, discuss the story per se (e.g., edit parts of the story, elaborate on key events), but also reflect on the experience overall discussing if and how they had benefited from it.

Literature on narratives suggest that through narratives and storytelling the identity of the individual can be expressed and even transformed, and give them the opportunity to better understand themselves through their stories (Crossley, 2000b; Hutto, 2007; Murray, 2003). The notion that individuals' identities are life stories is consistent among many fields of psychology (McAdams, 2001). By constructing and evolving narratives of self, individuals can achieve narrative meaning-making; coherence, unity, self-understanding and purpose (Fivush et al., 2017). Overall, the results from the follow-up interviews are in accordance with the literature, indicating the potential 'therapeutic' effect of NLI in regard to emotional well-being, something that is also demonstrated in the paired-sample t-test showing a positive impact of NLI on veterans' well-being and mental health status. NLI offered an opportunity to gain a more sophisticated understanding of personal experiences and in turn enhanced self-esteem. Sharing insights and positive memories and events, alleviated the effect of traumatic memories and brought joy and inner peace. Sharing a life story was an opportunity to understand the past and the present and obtain greater self-knowledge or realisation of certain burdens or

behavioural patterns, which is central to the recovery process (Schauer et al., 2011). This in turn led to the development of a clearer perspective on future goals. Obtaining a written copy of the life narrative and the freedom to share it, were considered a unique opportunity to allow others to gain a better understanding of the individual, but also to increase awareness of veterans' issues and support or inspire others to make a change. Sharing stories can be a way to show that some people have more in common that they think, helping to create a sense of community (Atkinson, 2001).

Limitations & Further Research

NLI is an interview process which combines key elements from an established interview technique (LSI) and a recognised psychological treatment for PTSD (NET). The results of this study indicated numerous benefits, which are in accordance with the various benefits reported specifically for the application of LSI (Atkinson, 1998; McAdams, 2008), the evaluation of NET (Lely et al., 2019) and generally from the narrative approaches literature (Fivush et al., 2017; Reese et al., 2011). Nevertheless, NLI was employed to conduct research with a small group of male traumatised military veterans. Further research is important to evaluate and establish NLI as a research tool. Recommendations for future research include the use of NLI with other groups of vulnerable people, who experienced different types of trauma, specifically with people who suffer from a specific mental health problem (e.g., either from PTSD, or depression, or anxiety disorder) to evaluate its effectiveness separately on common mental disorders. A comparison between male and female

participants, or participants who experienced the similar traumatic events but live in different countries would shed a light on potential gender and cultural differences. Important is to also monitor changes in emotional status or mental health, using psychometric measures. In this study measures were distributed twice (one before and one after the interview) due to time restrictions. It is recommended to monitor changes with psychometric measures but also follow-up interviews after one, three, six and twelve months to evaluate the effectiveness of NLI in the long-term and identify potential common areas where participants have been benefited the most.

Narrating a life story is not therapy per se, yet the act narrating can often help individuals achieve clarity, a clearer coherent narrative and a more sophisticated meaning-making. Individuals will not experience NLI the same way. Some individuals may find it 'therapeutic' and liberating to share their experiences and have an opportunity for self-reflection, while for others it may be a more painful process to re-visit negative/traumatic memories. Yet, individuals are free to share the experiences they want while narrating their life story, thus by choosing to share a specific experience, they are ready to come forward and disclose their feelings and thoughts regarding this event, which in turn can lead to positive outcomes. The life story interview is a helpful psychological research approach which allows researchers to gain a subjective perspective on and understanding of the broad scope of topics or issues that individuals experience (Atkinson, 1998, 2001). NLI should be considered as a research tool which will accommodate the research purposes and at the same

time actively engage participants in narrating, reflecting on and achieving self-understanding through their own life story.

4.6 Part 2: The Narrative Construction of Reality

Two stories have been selected as exemplars based on their ability to be analysed in terms of their narrative structure (i.e., both long interviews that provide rich detail) allowing the researcher to obtain a more in-depth picture of the lives of those two traumatised veterans, identify patterns of behaviour and a narrative identity. Pseudonyms were used to preserve anonymity and confidentiality.

John's (34 years old) and Joe's (40 years old) stories, are two engaging, rich and insightful narratives, portraying vividly many pre- and post-military experiences, as well as the impact of these experiences on the individuals' identities and transition to civilian life. These two stories have been selected:

(i) on the basis of what they have in common: both individuals experienced a difficult life before joining the military and both were medically discharged due to permanent physical injuries and later developed mental health problems (both got an official diagnosis at some point in their life).

(ii) because of the different ways those two individuals manage their transition, with the one being able to better reintegrate into civilian life. That is also apparent in participants' scores overall (Table 8): John's scores are lower, opposed to Joe's, which are higher.

Table 8 Participants' scores

	Pre-test			*Post-test*		
Participants	*HADS D*	*HADS A*	*PCL-5*	*HADS D*	*HADS A*	*PCL-5*
Joe	11	17	50	10	15	43
John	7	13	39	6	12	30

4.6.1 Story 1: Redemption Sequences & Narrative Identity

4.6.1.1 John's Story

John grew up in the North Midlands. He grew up with his mother and his two younger brothers because his dad abandoned them when he was young. His mum was a police officer, and his dad was a professional motor biker. John was an active child and since he was 4 years old, he had been expressing his need to belong in a group. His mum supported him during this journey and started him playing rugby. John always wanted to progress and stay fit. He joined the boy scouts while continuing playing rugby semi-professionally, and later in his life he joined the cadets. School was a difficult time for him, even though he was not misbehaving. He left school with no qualifications but that did not stop him from wanting to do something with his life. John had always admired the military history of his family, which had been in his family since WWI. That was why he decided to join the military. His mum supported him during the application process thinking that this experience would help him build his character. John was successful with his application and his training and joined

the army, remaining for 4 years. These years were challenging, but he managed to grow through his experiences. He worked hard to be a good soldier, prove himself and progress. John managed to re-sit his GCSE exams and apply for a promotion, aiming to build a career in the army. He was proud of some situations, such as participating in the UN peacekeeping operations in the Balkans, yet he felt that he did not have the opportunity to shine and progress his career as he was medically discharged due to a knee injury. John was disappointed with the way the Army treated him, as he claims he was not offered the appropriate rehabilitation or guidance on how to manage his injury and transition from military to civilian life. John did not want to leave the Army and the nature of his discharge put him in a vicious cycle unable to cope with his transition. He was drinking heavily, spending most of his money on alcohol. John's employment and economic transition was also challenging and as a result he was forced to move in with his disabled dad in a one-bedroom council flat, struggling to survive day-to-day. His mum had to retire from the police force as she had developed severe depression during service. He asked for his mum's support, but she refused, telling him that he had to learn his lesson the hard way. John tried to get back to the Army or RAF, but he was unsuccessful. This period was a very low point for him; he was struggling mentally and was unable to maintain friendships or intimate relationships. Even though he moved in to a flat by himself, he got evicted and ended up living on the streets for ten months.

An opportunity to make a new start by working in a retail shop came from a friend. From that point onward, John did not stop fighting for a better future.

He worked hard, he progressed and saved money to make his dreams come true. His girlfriend at the time supported him financially but was unable to offer intangible support while he was struggling with his mental health, which deteriorated over the years. He was suffering from anxiety and panic attacks and later he was diagnosed with depression, having to start taking anti-depressants. Nevertheless, John decided to use all the transferable skills he was taught not only in the Army, but from all the challenges he had to overcome to survive. For John, the turning point was when he allowed himself to understand and accept his life experiences and the consequences, such as his mental health problem. He stopped drinking heavily and taking the anti-depressants. His girlfriend's patience, love and support were valuable during this effort to stand on his own two feet. John is proud of himself because, regardless of all the struggles and challenges, he managed to find the balance in his life, even if it took him a decade to do so. He now works in the food industry and never stops aiming high. John is with his girlfriend for more than 10 years, and he wanted to get married and have children. He remains ambitious, full of dreams and aspirations for a positive future in a personal and professional level.

4.6.1.2 Data Analysis

John constructed a story that showcased many instances of redemption sequences (McAdams, 1999), despite the numerous negative events or states. In Table 9 Redemption Sequences, the key redemption sequences of John's story along with examples are presented. The plot in John's narrative moves

from emotionally negative events to good ones and through his life initial negative states are '*redeemed*' by the good that follows them. The next sub-section (Table 10 Life-Story Constructs of Narrative Identity) shed a light on John's narrative identity (McAdams & McLean (2013) framework) as an internalised and evolving life story, which integrates his reconstructed past, perceived present, and imagined future. John's '*Narrative Identity*' analysis allows the exploration of connections between his narrative identity and personality along with his motivation, values and approaches to life. A summary follows on Section 4.6.1.3.

Table 9 Redemption Sequences

Growth	
A: Negative State	***B: Positive State***
His dad abandoned his family when children were young and as a consequence John developed trust issues.	John gained personal strength and became more assertive in his relationships from a young age.
Leave school with no qualifications.	Initiated personal change: -Makes the decision to join the Army and do something with his life. -Re-sit GCSE exams in order to achieve rank progression.
Unable to manage his transition to civilian life and ends up homeless for 10 months.	He puts his life in perspective and starts taking responsibility for his life.
Being medically discharged from the Army, suffering from depression, alcohol dependence and unemployment.	He experiences personal growth and self-understanding, learning to stand on his own two feet.
Recovery	
A: Negative State	***B: Positive State***
Alcohol misuse for years after he was medically discharged from the Army.	Make a conscious decision to stop drinking heavily in order to progress in his life.
Suffering from panic attacks and diagnosed with depression.	Managed to accept and effectively cope with his mental health problem to reduce its impact on his life.

Learning

A: Negative State	*B: Positive State*
Lack of opportunity to shine and build a career in the Army.	He develops new skills and learns how to think analytically and better cope with the challenges in life.
His mum refused to support him while struggling with his transition to civilian life.	He learns the value of hard work to achieve goals by himself.

Improvement

A: Negative State	*B: Positive State*
Experience a decade of chaos in his life.	He manages to overcome the challenges and now experiences a happier time in his life.
Difficult years working in low-paying jobs and not enjoying life.	John managed to save money, enhanced his life and slowly started fulfilling his dreams.
Unable to stay in a relationship as his ex-girlfriends were lacking empathy.	His current girlfriend is patient and shows him love and understanding. They are together for 10 years.

Table 10 Life-Story Constructs of Narrative Identity

	John's story	***Example Quote***
Agency	John was able to affect change in his own life regardless of all the challenges he had to face during and after his military service. John demonstrated his self-efficacy, strength of character, sense of achievement and his ability to control his own fate.	*"I was then homeless for ten months […] I asked to move back in with Mum, she said no […] she's a firm believer in life's hard lessons and if you're going to learn you're going to learn hard, I kind of appreciate that now… I won't lie, I won't change the way that it's gone because I appreciate the way it panned out, sometimes the hard lessons need to be learnt…"*
Communion	John's dad had abandoned them when he was a very young child and John developed trust issues, yet he managed to use it on his benefit and experience interpersonal connection through love (for significant other and family members). John's story emphasises caring and belongingness especially with: (i) His girlfriend who supported him during the decade he was struggling with his transition	*"My relationship back then supported me a lot… We had our own issues, but she* [current girlfriend] *was definitely a support for me, not so much financially, but emotionally and situationally definitely, because she provided a situation, I then worked to make it work […] now I'm to a point where me and my partner, we're hopefully looking at buying a property in the next year and then come to the marriage".*

	(ii) His young brother who also suffer from depression and John managed to help him cope due to his own experience.	*"my little brother J., he's been having a lot of problems with depression recently […] I understand completely, so that first of all allowed me to help deal with him without getting frustrated, without going 'oh, you're wasting my time, go away', because my mum and my step dad, they just kind of said 'shut the fuck up, get on with it' - it just didn't work".*
Redemption	John demonstrated through his narrative that he is able to cope with emotionally negative events or difficult situations and manage to achieve a positive outcome.	*"I had a very bad coping strategy which was drinking, very bad, very very bad. When I left the Army I was flat out, I was a wreck, I'm not going to lie, I would destroy a quarter bottle of whiskey before 7 o'clock in the morning […] I completely blacked out and they basically turned round to me and said, "if you carry on drinking the way you drink you're going to kill yourself", and that's it! I haven't been drunk ever since".*
Contamination	Even though John had to face many challenges for almost a decade after leaving the Army, he does not present these negative events in a dramatic way, but rather he and tries to promote the positive outcomes. The negative situations are not presented as	n/a

	contamination sequences, as John acknowledges what happened and managed to learn from it, experience personal growth and become more resilient through these difficulties.	
Meaning making	John shows no regret for having to face all these challenges after leaving the Army because he learnt a concrete lesson and gained a deep insight about life, becoming who he is today.	*"…you are the centre of your own universe, you are the crux of what you make, and in order to achieve anything the first person you need to look to is you. That's something, that's an ethic that I've had all the way through my life, and that's also why I think that I've stayed strong in the hard times, and now I appreciate what I appreciate, because of that".*
Exploratory narrative processing	John demonstrated the development of a richly elaborated self-understanding through his life experiences, acknowledging the struggles as a way to mature and become stronger and better over time.	"*I'm confident with the skillset that I have, that I can lose my job, I can lose my flat, I can lose my car all in one day, which has happened before - I've faced it, but I've worked for it once and I'll do it again. So, like I say, anyone with the right mindset and a little bit of support behind you - anything is possible…"*

Coherent positive resolution	John's tensions in his story are resolved (e.g., progress in his professional life) or manageable (e.g. being able to stop the anti-depressants and cope with his depression). This led to closure and a positive ending.	*"I really started to appreciate and sit down with myself and, sort of accept it - more acceptance, there's no sorrow, there's no remorse there's no guilt, it's part of life and get on with it. It sounds so very cold but at the same point you just need to brush it under the carpet and you can't let it drag you away, which is why I think I've been as successful as I have".*

4.6.1.3 Summary

John's negative experiences lead to psychological and interpersonal growth over time. Even though at times he wilfully accepted extremely negative 'states' (ill physical/mental health), he manages to successfully obtain a positive state, slowly heal and enhance his interpersonal adjustment. Over time, he gains new knowledge and skills or uses past experiences to successfully navigate responsibilities and resolve practical challenges involved in his employment and economic transition. John constructed a life story that showcased many instances of redemption sequences. Contamination sequences were also acknowledged across his life story; when he had to face many emotional and practical challenges as a young individual, such as growing up without his dad, as well as an adult, such as being medically discharged from the military, unable to 'fit in' civilian society or manage his professional life and overall psychological health. Despite the numerous challenges, he managed to sustain his confidence and hope, which were necessary to handle setbacks and mental health problems. Yet, John does not present setbacks solely as negative, but as an opportunity to learn how to survive, mature and become better and stronger over time. The redemption sequences across his narrative mark the transitions from emotionally negative scenes to positive outcomes or attributions about himself. John's positive attitude towards life, despite the setbacks or emotional challenges, was the key factor that motivated him, helped him overcome life and career challenges, achieve certain goals in life and cope with his mental health problems.

Overall, John's narrative indicates a quite sophisticated self-understanding and meaning-making, which link his life experiences to his current sense of identity. John provides the quality of chronological, context and thematic coherence. He has his moments of clarity and shows understanding of how and why specific events unfolded as they did, with the links among actions, internal states and identity being clear and concise. John expresses subjective perspective by recognising and describing thoughts and emotions and provides integrative meaning by elaborating on the reasons why certain changes occurred over time. His narrative is highly integrative and reflective, displays great insight and exploration and provides a compelling story of his life experiences. Indeed, despite the numerous challenges that John faced in the past and still trying to overcome, he demonstrated his ability to create coherent, integrative meaning and in turn achieve inner growth, self-development and a larger sense of purpose.

4.6.2 Story 2: Contamination Sequences & Narrative Identity

4.6.2.1 Joe's Story

Joe was born in an ex-British colony. He has blurred memories regarding his early childhood. He realised later that he was separated from his parents because they were members of the chief family and his upbringing had to be in accordance with the traditions and culture. He grew up with his uncle and his auntie and their child, thinking that they were his parents and his brother. Joe reminisced his life in the island and the wonderful experiences he collected living close to the sea. He loved the life there because he was feeling free and independent. Even though he was not the best student, he was full of energy and dreams for the future. Traditionally, school was not a priority, so Joe spent his time focusing on supporting the family, for example feeding the animals or clean the house. For him these were valuable lessons as he learnt when and how to cultivate the land and how to take care of the farm animals. When he was around eight years old, he was introduced by his uncle to his dad for the first time. It really took time for him to realise and accept the truth about who his dad and mum was.

In the meantime, his teachers encouraged him to sit the national exams in which he was successful, yet that meant he had to move to the big city with his real parents in order to continue his education. Joe was around twelve years old when that happened. It was a difficult decision for him to leave the island even thought he was happy he could progress in school. Joe had to manage his transition from the very traditional life in the island to the multi-cultural, more western city life. However, his transition to the new school was quick as he had

the valuable guidance of a teacher who supported him during his transition. Joe has high educational aspirations and wants to study in the university. On the contrary, his relationship with his family was not very good. He was feeling like a stranger, unable to maintain the balance between himself his parents and his two siblings. He was also heartbroken as his parents did not show any love and support towards his efforts to study and progress. When he is sixteen, his parents put a lot of pressure on him to leave school and abandoned his dreams for the future, in order to follow the tradition and agree to an arranged marriage. Joe had to stand up for himself to escape from this situation but as a result of this constant pressure and disappointment he fails his exams and has to repeat the grade.

After hard work he started studying Law at the University where he experienced better self-understanding and personal growth and managed to make the conscious decision to keep a distance from his family. During his second year at the university, when he was around twenty-two years old, unexpected circumstances led him to discover that he had a different biological father than the one he thought. Joe felt betrayed as his mum lied to him for the second time regarding who his dad was. He decided to give an opportunity and let his real dad in his life. Slowly they formed a strong bond and Joe felt a real connection with this person as opposed to all the negative feelings he had towards his family. When he was twenty-one his parents put pressure on him for the second time to stop his education and leave all his future dreams behind, in order to get married.

That was the point when Joe realised that he was the master of his own fate and he was the one to decide for his future and not his parents. Joe was very passionate about law and politics not only as part of his education but also as part of his life values. After witnessing 9/11 incident during a Skype lecture, he shaped a strong opinion and ideology about security and international terrorism. That was when he decided to join the Navy against his parents' will. Two main reasons led him to make this decision; his need to escape from his family, explore the world and be close to the sea again, and his belief that through the Navy he will be part of something bigger and fight terrorism. Joe served for eight years and collected some really good and unique memories during this time. He enjoyed his independence but also the responsibilities that came with it. He aspired and adopted the values of the Navy and that helped him feel that he belonged in a real family. He was trained as a chef, which he found fascinating and really enjoyed. Nevertheless, his career involved challenging moments which had a negative impact on his physical and mental health. Joe managed to receive the Commodore Award for excellence, for saving an injured member of his team during training. This was one of the most significant moments for him. Unfortunately, during his effort to carry his teammate he injured his knee. Joe felt that his injury was not investigated properly by the Navy physicians and medical officers and as a result he has never managed to fully recover from it. Joe experienced another accident while he was on duty. He got electrocuted but did not receive immediate attention something that had a permanent negative impact on this health. Joe's lowest point was when he witnessed a near-death accident while on duty

on the naval ship. Due to the extremely heavy weather and sea storm that day, two sailors fell off the ship, who eventually were rescued. Joe had specific responsibilities during the incident, thus he could not actively get involved and that was something that haunted him and made him feel like a failure. After that he developed PTSD, which was officially diagnosed by chance after a few years when he had to do his knee operation. Joe became very aggressive and had nightmares, he was getting into trouble and struggling with everyday tasks. The consequence of poor diagnosis and treatment was that he had to work in an office rather than being on active service and was ultimately medically discharged. Joe was very disappointed, feeling betrayed and mistreated by the Navy, as he was left with no support and guidance to cope with his mental and physical health problems. All this had a negative impact and long-term consequences on Joe's quality of life and well-being during his transition to civilian life. In his effort to cope and overcome these challenges he became an alcohol addict. For many years after his discharge, Joe was limited on what he could do physically due to his knee problem, he could not maintain a job, he broke up with his girlfriend and could not see his daughter anymore. While Joe was struggling to put his life in order he decided to apply to go to the university, but during the first two years his PTSD was at its peak and he was unable to cope with it and successfully manage his daily responsibilities.

Eventually, he got in touch with a local armed forces charity and started therapy which helped him to understand what PTSD is, slowly learn how to cope with it and successfully manage everyday challenges. At this point in his

middle adulthood life, after many years of struggle, Joe acknowledged who he is and visualised the person he wants to become in the future. This realisation led to improvements in his social (stopped isolating himself and became more confident in social situations), personal (his relationship with his daughter is improving, reduced PTSD symptoms) and professional life (set new aspirational goals to progress). After accepting himself with his strengths and weaknesses, he managed to move forward, Joe felt more confident to set a path to his personal and career goals and successfully navigate life.

4.6.2.2 Data Analysis

Joe constructed a story that showcased many instances of contamination sequences, despite the positive events or states. The plot in Joe's narrative moves from emotionally positive events to negative ones and through his life initial acceptable or mildly positive states are '*contaminated*' by even worse things that follow. The contamination sequences (McAdams, 1998) of Joe's story along with key examples are presented in Table 11 Contamination Sequences. The next sub-section (Table 12 Life-Story Constructs of Narrative Identify) shed a light on Joe's narrative identity (McAdams & McLean (2013) framework), and the connections among his motivation, values and approaches to life. His narrative is edplored as an internalised and evolving life story, which integrates his reconstructed past, perceived present, and imagined future. A summary follows on Section 4.6.2.3.

Table 11 Contamination Sequences

Betrayal & Victimisation

Good Event	***Contamination***
Happy living and learning in the island feeling free and independent.	He learns that the people who raised him were his uncle and auntie and not his real parents. He meets his dad when he was 8 years old.
Trying hard to adapt to the new life in the big city and works hard to be successful in school.	His parents do not show any affection, support or admiration towards him and his achievements. His parents break his heart.
Being able to study Law and experience personal growth and self-understanding.	When he was eight, he discovers that his biological dad was someone else and that his mum lied to him for the second time.
Decides to be his own man, join the Navy to serve a higher cause and explore the world.	He gets a lot of pressure and criticism from his family.

Loss & Failure

Good Event	***Contamination***
Being successful in national exams and progress towards education.	He has to sacrifice his life in the island, move to the big city and leave with his real parents.
His parents are not proud of him and his academic achievements.	He fails the exams because of this, and he has to repeat the grade.

Disappointment & Disillusionment

Good Event	***Contamination***
He has high educational aspirations and wants to study Law at the university.	His parents force him to stop his education twice for an arranged marriage. He has to stand up for himself to escape from this situation.
He feels proud for serving in the Royal Navy, Follows and respects the military values.	He feels betrayed and disappointed by the way he was treated regarding his physical and mental health which led to his medical discharge.
He lives by strong values and even after his medical discharge he feels he was part of something greater (i.e., serving in the Navy).	He realises that serving in the military is not highly respected by civilians.

Physical & Psychological illness

Good Event	***Contamination***
Receives commodore award for excellence for saving an injured member of his team during training.	He injures his knee and does not get the appropriate investigation and support from the Navy physicians and medical officers. He has never fully recovered from this injury.
His career in the Navy is progressing and he now gets promoted as a fire fighter leader.	He witnesses a near-death accident on the ship, but he could not actively help the crew. He feels a failure and develops PTSD.

Table 12 Life-Story Constructs of Narrative Identify

	Joe's story	***Example Quotation***
Agency	Joe's story is a low agentic story overall and lacks the ability to control his fate. Joe tries hard in his life course to affect change and influence others in his environment, but he always feels he cannot easily demonstrate self-mastery and empowerment.	*"This was the time I had to find a job and I didn't really want to stop my education. They stopped my dream for an arranged marriage and that was extreme. They stopped me from graduating and being a lawyer, because I would then leave the family and start working with my real dad who had an office. I cried…"*
Communion	Even though Joe's experiences interpersonal connections as a young individual, the lies about his biological parents ruin it and undermine the feelings of intimacy and belongingness. Also, Joe loses the opportunity to experience interpersonal connection with his daughter for many years due to his mental health problems.	*"I would like to be able to visit her* [his daughter] *more often but because of my PTSD I was afraid I may have an episode […] I promised myself that when I feel safe and confident, I will start seeing my daughter more often".*

Redemption	There are some scenes in which emotionally negative circumstances lead to positive ones. Overall though, Joe's present his story indicating that usually positive events turn into negative, feeling that it erases the effects of the preceding positivity.	*"Freedom is the most important for me. When I was a child I had to listen to my parents, when I was going to churches I had to listen to priests, to school the teachers, when I joined the Army I listened to my leaders, but now it is the first time I listen to myself!"*
Contamination		
Meaning making	Joe had to face many challenges in life since he was a child and even though he was proud of serving in the military he felt mistreated and betrayed. Through his life, physical and mental health struggles over 39 years, he understands that the biggest challenge was to discover himself. He comes to the realisation that 'freedom' was the ultimate value that he was missing all these years and the main reason he could not be himself.	*"I think my biggest challenge in life was to discover myself and what I can offer […] I think it is the first time I am listening to what I am thinking, and I express it as well".*
Exploratory narrative processing	Due to his life challenges, cultural issues and family background Joe was brought up, he did not have the opportunities for self-exploration and self-understanding. He struggled over the years to shape his own identity, but his life circumstances were misguiding him. Currently he is trying to set new goals, see the positive aspects of things and appreciate what he has achieved so far.	*"The biggest loss in my life was the loss of my identity […] Some people said I was a black man with an English heart - that was harsh […] I had cultural issues as well, apart from not being in the Navy anymore. I guess I could call myself a veteran, but I am not exactly proud of it. I think I lost my identity, my pride to serve the Queen. I lost my best job ever, I lost travelling… I feel*

		however, I am building my world, setting my priorities again… I managed to accomplish something, starting from a school in the village and almost finishing my studies at the University".
Coherent positive resolution	Joe slowly leaves all his troubles behind and sets new goals for the future. He now puts his life in perspective; he tries to prioritise the things that are important for improving his well-being and quality of life, gain personal strength.	*"…I started putting everything in order again. Sometimes life is easy sometimes it's difficult but that's the tricky part of being human as well. Every life has its way to success but there are different meanings of success as well. A local proverb is 'Dogs always find their way home'. What this means is that life always provides a path or a way to your destiny…"*

4.6.2.3 Summary

Joe's story indicates a pattern where good states/events cannot be recalled without being paired with negatives. Joe experienced a happy childhood but over time he faces betrayal and loses his trust over key individuals in his life (e.g., being lied twice about his biological parents). He is in a constant battle to prove himself, live by his values, achieve new things and progress (e.g., study at the university, progress in the Navy), yet negative events/states cancel out his efforts (e.g., pressure from his parents, ill health during and after the Navy), undermine his individuality (e.g., cultural issues) and undo the previous good events/states. Joe constructed a life story that showcased many instances of contamination sequences. He had to face many emotional and practical challenges as a young individual and an adult. After being medically discharged from the military, with ill mental and physical health, for a long period of time he was feeling unable to 'fit in' civilian society, manage his employment and economic transition and overall psychological health.

Joe's life narrative account indicates that the various challenges he had to face, such as his physical injuries and PTSD, stopped him from progressing, decreased his emotional well-being and hindered his efforts to overcome setbacks. In Joe's narrative, good and happy moments as well as some redemption sequences (e.g., stand up for himself against his parents' pressures, join the Navy), are acknowledged. Yet, the way Joe decides to narrate his story shows a behavioural pattern over the years; Joe felt that he never had a real opportunity to freely be who he wanted to be and express his

thoughts and feelings to people around him. Despite his efforts over the years he let negative events and states to drain him emotionally and eventually define him. The contamination sequences across his narrative mark the level of difficulty in maintaining emotionally positive scenes and outcomes. Joe respected education and continuous learning and over the years he developed his own ideology about how the world should be. Nevertheless, Joe's emotional freedom and positive attitude towards life have been supressed since he was a child, either by others or himself. The lack of the above, in combination with his life circumstances, misguided him and led to identity crisis and self-confusion.

Overall, Joe's narrative shows lack of sophisticated understanding and meaning making, which lead to identity confusion. During his narrative Joe has trouble defining the things that interest him in life, his social viewpoints or professional ambitions and provides a lower quality o chronological context and thematic coherence. Joes demonstrates a certain level of subjective perspective and overall a lack of understanding of how and why certain events unfolded as they did and were accompanied by certain thoughts and emotions. Across his narrative, there is a low level of reflection on how his own perspective may have changed as a result of specific events and experiences. His narrative does not demonstrate high coherent and integrative meaning, but rather employs short-term solutions to resolve problems. This hinders his inner growth, self-understanding and the creation of a new perspective and a larger sense of purpose. Things changed for Joe only recently in his middle adulthood, when he realised that he has prioritise himself to achieve his goals

and actively work on managing his mental health problems effectively. While narrating, Joe came to a realisation that the opinions of others or themes from his cultural background were always a major barrier and felt more confident regarding his true self and identity. Towards the end of the narrative, his current situation is described as a '*state of salvation'*, indicating a more holistic insight of self and an increased thematic coherence.

4.7 Discussion

The aim of narrative analysis was to obtain an in-depth understanding of how veterans' personality traits, culture, values and general approaches to life may facilitate identity formation or lead to identity confusion during transition to civilian life, shortly after but also in the long-term. Current results demonstrate both the negative consequences of life experiences (especially military experiences), such as ill metal and physical health, and the positive impact, such as developing resilience and adaptability over time. It is essential to understand the psychological reactions of military personnel when witnessing or experiencing traumatic situations, as the unresolved issues occurred by traumatic exposure continue to hinder their quality of life in the long term.

Exposure to trauma and the development of high levels of anxiety, depression, anger symptomatology or PTSD is associated with profound and lasting changes in an individual's identity, across civilian (Herman, 2015) and military populations (Demers, 2011; Stevelink et al., 2018). Military ways of being become deeply embedded to individuals and can continue to influence, in complex ways, their behaviour and identity long after their transition to civilian

life (Caddick et al., 2018). Current results indicate that even among veterans who suffered physical injuries or developed mental health problems, there are factors that distinguish those who managed develop and inner understanding and better adapt to civilian society, to those who lost their sense of self.

Life narratives tend to focus on the most significant events, either positive or negative, as these are the experiences that shaped individuals over time and it is crucial to make sense of (Adler et al., 2016; McAdams et al., 2001). Yet, individuals' interpretation of similar experiences and the way these will affect them may differ. A more redemptive life story was told by John, an individual who was always driven to live a meaningful life, despite the difficulties he had to face, and at the same time he was able to understand, interpret and learn through his life experiences. On the contrary, Joe's narrative included more contamination sequences; despite having dreams and aspirations and trying to live a meaningful life, cultural themes and significant others restricted him from growing and developing a strong sense of identity. He continuously interprets his life as going from good to bad and his narrative indicates low understanding and ability to learn by and grow from his life experiences. Yet, towards the end of his narrative he realises that he is in control of his life and that meaning-making can be developed from his hardships. The specific ways individuals think about and plan their lives can affect personal growth and intentional self-development. These findings suggest that more optimistic explanatory styles and constructive envisioning of the future may help less psychologically resilient individuals to cope more effectively with the numerous consequences that can occur due to ill physical or mental health

(Schaubroeck et al., 2011). Redemption and contamination stories (McAdams et al., 2001) are just two kinds of tales; results are in line with the literature (Bauer & McAdams, 2004; McAdams et al., 2001; Thompson et al., 2017) indicating that individuals who tend to tell stories defined by growth, communion and agency allow them to shape a more positive identity. The self-understanding they obtain by telling, reading, editing and reinterpreting their stories, leads to an increased sense of control in their lives, self-respect and the development of a larger sense of purpose.

One way to improve psychosocial well-being and rebuild identity is through developing one's life story. The narrative identity is a way to process negative/traumatic life experiences and can affect pathways of personality and identity development and the experience of physical health in adulthood (Pals, 2006). Indeed, results suggest that narrative development enabled veterans to process and make sense of their experiences, integrate traumatic memories into autobiographical memory (Hunt, 2004) and obtain a more sophisticated understanding of who they are and who they want to become in the future. The way veterans chose to interpret their life story and life transitions correspond to specific forms of personality development. Results suggest that when a transition narrative, regardless of the difficulties encountered, emphasises the redemption sequences, all the negative states and emotions that turned to good ones, indicate higher levels of self-understanding and social-cognitive maturity (Bauer & McAdams, 2004), whereas narratives that emphasise contaminations sequences during life transitions, interpreting life events as going from good to bad, tend to have lower self-understanding,

difficulties in creating meaning-making and thoughts that their lives are less coherent (McAdams et al., 2001). The similarities and differences in participants' narrative accounts could offer a more sophisticated perspective on this complex research topic and the reasons why veterans with similar negative/traumatic experiences and hardships before and during their transition to civilian life, eventually manage to cope better than others. The theory of narrative identity suggests that individuals form an identity by integrating their life experiences into an internalised, evolving story of the self, something that in turn can provide the individuals with a sense of unity and purpose in life (Hammack et al., 2008; McAdams, 2011). The ability to create modes of meaning making does not end along with the narration. This study also indicates that when someone tell their life story and at the same time truly engages with the process, trying to elaborate on past behavioural and emotional patterns and revise his approaches to life to achieve inner growth, ultimately can adopt a more positive identity which will enable them to live more purposefully.

Limitations & Future Research

The small sample size, the variation in years of service and length of transition and lack of representation female veterans means caution should be taken when considering these findings in terms of the wider veteran population. The study used volunteer participants and it is likely to have had a selection bias toward people who either had started to develop a more positive view of their transition or were individuals who generally like to share their experiences, tell

their life stories and engage with other individuals. Thus, there are limitations on the capacity to generalise this sample of military transitions to its general population. Of note here, a narrative approach provided temporal insights into the veterans' experiences, indicating the way they feel, and they see themselves in the present time. Depending on their life course and self-development, the way they interpret past experiences may change and as a result a different life story may be narrated in terms of coherence, subjective perspective, integrative meaning and motivational themes. There are many ways to conduct narrative analysis. The aim of this study was to understand veterans' story as a whole and the links between their subjective pre-military, military and post-military experiences shaped who they are now, as well as how they as individuals interpreted their lived experiences, made sense of their life transitions. Yet, what people report about their lives does not necessarily reflect how their lives actually operate, thus this study may well be subject to self-report biases. That was not an issue for this study as the main interest was to observe if and how interpretations of significant positive and negative life events, including all sorts of personal biases, have implications for how veterans cope with their traumatic experiences, managed their transition and planned or not their life course. Finally, the length and nature of this narrative study may affect how comfortable and confident individuals will feel to share their stories. Even though that was not a limitation of this study, as participants were willing to open up and share more details about their life experiences than it was required, the content of the interviews may have deterred less confident veterans from taking part. Future research on military

and ex-military population, should consider the unique strengths of narrative approach as it highlights a side to veteran transition experiences that does not often receive as much attention in current research studies and in clinical practice, such as the importance of making sense of psychological and existential experiences and how those can facilitate or hinder the way veterans link their subjective consciousness with life experience and identity. The combination of quantitative, qualitative and narrative data could ultimately help researchers and clinicians to shape a more sophisticated understanding of veteran population and in turn conduct targeted research and develop more effective interventions.

4.8 Conclusions

One way to improve psychosocial well-being and rebuild identity is through developing one's life story. The narrative identity is a way to process and elaborate on negative/traumatic life experiences, something that can affect pathways of personality and identity development. The application of NLI as a research tool indicated its 'therapeutic' effects (different from clinical model approaches) and multiple benefits for veterans, yet to establish it as an effective research tool in narrative research it needs to be used with other vulnerable groups of people, both male and female. Overall, narratives enabled participants to present both their positive and negative/traumatic life experiences, thoughts, and feelings, while at the same time they were encouraged to interpret and elaborate on behavioural and emotional patterns. In turn, this allowed the researcher to obtain a deeper understanding of participants' lives holistically, rather than in traumatic experiences specifically,

exploring social and psychological outcomes as well as the implications on identity and self.

Chapter 5: Sport as an Intervention for Physically Injured Military Veterans - The example of Competitive Motorsport

5.1 Introduction

One of the cultural consequences of being mentally or physically traumatised is that an individual's identity as a complete person comes into question (Hunt, 2010). Military personnel might be left 'stuck' at a particular point of their military life, where challenging events occurred. This can make it very difficult to continue their life course in a meaningful way and can negatively affect their transition from military to civilian life. These problems can be dealt with a number of ways such as, conventional therapy, talking to friends or family. However, as previously mentioned in Chapter 1, many thousands of veterans receive psychological treatment for their war-related problems. This is not effective for all of them, because of the stigma attached to mental health and the difficulties associated with talking about their traumatic experiences (Hoge et al., 2004; Vogt, 2011). As physical and emotional weakness are discouraged during military training, many veterans struggle to accept their physical injury or mental illness. Such barriers to care hinder veterans' rehabilitation and recovery and can lead to increased risk of suicide, drug and alcohol misuse (Hyman et al., 2012). It becomes difficult for mentally or physically traumatised veterans to find short- and long-term benefits in conventional therapeutic interventions, such as counselling, cognitive therapy, medical treatment or technology-based treatments, which are currently offered to them (Cornish et al., 2014; Cukor et al., 2009, 2010). Military veterans benefit from different

types of activity, depending on their needs (i.e., type of physical injury or mental health problem). Since military culture makes it difficult to accept the stigma of mental illness or physical injuries/disability, many prefer to cope with various stressors either by employing (i) maladaptive coping strategies, such as alcohol misuse or aggressive outbursts (Hyman et al., 2012) or (ii) adaptive coping strategies, such as non-therapeutic approaches (Caddick & Smith, 2014; Crossley, 2000a; Hunt, 2010). Finding ways to identify those who may benefit most from sporting activities, or indeed from psychological therapies or both, would provide an effective way to reduce the adverse consequences of traumatic experiences. Non-conventional interventions, such as sport, have a clear part to play in this in providing a means to enhance experiences with family and friends, and to enable veterans to have a more fulfilled working life (Dietrich et al., 2015; Hoge et al., 2004).

5.1.1 Physical Activity & Military Veterans

Physical activity is the key factor of health maintenance and chronic disease prevention for all individuals with or without a disability and the numerous physical and psychological benefits associated with exercise are well outlined in the literature (Vartanian et al., 2012). It is also well-documented that non-pharmacological therapies, such as physical activity interventions and sport are beneficial for cognitive function, mental and physical health to general population of any age group (Carvalho, Rea, Parimon, & Cusack, 2014; Groot et al., 2016; Holt, 2008; Sahlin & Lexell, 2015; Van Raalte & Brewer, 2014). Such interventions can be an effective alternative or add-on option to current

pharmacological treatment as they promote values and enhance the well-being and psychosocial health of people with disabilities and/or mental health issues (Hefferon et al., 2013; Ginis et al., 2012). Additionally, sports offer individuals the opportunity to find enjoyment, express intrinsic motivation and provide potential space to renew self-esteem that may be lost in other areas of life, such as work and personal relationships (Hawkins & Lynne, 2011).

Nature-assisted approaches (NAT) have been found to be effective and appropriate as a relevant resource for public health, indicating the positive effect of nature on mental and physical health for diverse groups of people, such as individuals suffering from dementia, schizophrenia, cancer, physical injuries or obesity (Annerstedt & Währborg, 2011). Similar interventions can also be of benefit for ex-military population. Military veterans are individuals who can be motivated by moderate or intense physical activity that requires practical skills (Poulsen et al., 2015) or sport that may involve high levels of adrenaline, competition and achievement (Betthauser et al., 2017; Lee & Uihlein, 2019). Masculinity is an important influence on health behaviours, especially for men, as it can be implicated in their health-defeating practices (Sloan et al., 2015; Smith, 2013). Current research indicates that physical activity interventions can have a significant and holistic positive impact on veterans physical and mental health, including improvements on quality of life and social well-being, motivation levels and positive self-image post injury, as well as PTSD symptom reduction (Caddick & Smith, 2014; Dustin, Bricker, Arave, Wall, & Wendt, 2011; Otter & Currie, 2004). More specifically, a systematic review of 11 studies relating to the use of physical activity and sport

in supporting combat veterans, showed the value and the multiple positive effects of sport and physical activity in veterans' motivation and psychosocial health following disability and/or psychological trauma in combat (Caddick & Smith, 2014). These studies suggested that competitive, rule-bound and structured activities can help veterans with their transition to civilian life (Mowatt & Bennett, 2011). Active coping and the ability to do something important again enhanced veterans' subjective well-being. They reported a positive impact on their focus, determination, identity, inner strength, social skills, sense of accomplishment, and ability to broaden their horizons and knowledge by accepting their disability or mental health problem (Brittain & Green, 2012; Burke & Utley, 2013; Carless et al., 2013; Hyer et al., 1996). These positive psychosocial effect and outcomes can inspire veterans and enhance their general motivation for living (Lundberg et al., 2011; Sporner et al., 2009). NAT and Wilderness Experience Programmes (WEPs) (e.g., climbing, hiking, kayaking, adventure courses) have also gradually become more common and accepted in the UK and the US as an alternative rehabilitation plan not only for civilians, but also for physically and mentally traumatised military combat veterans (Dietrich et al., 2015; Poulsen et al., 2015). Poulsen et al. (2015) conducted a systematic review, including 19 studies of horticultural- and wilderness-based therapies showing that nature can become a potential therapeutic resource by providing an opportunity for reflection and restoration. For example, socialising with others, planning and performing new tasks had a positive effect on veterans.

5.1.2 Extreme Sport & Competitive Motorsport

Extreme sport covers a wide range of high-risk activities that are related to the 'adrenaline rush' and emotional arousal and most of the time require particular equipment and safety gear. These type of sport are associated with high level of danger as any mistake could result in injury or even death (Brymer, 2010; Brymer & Schweitzer, 2012). Examples of extreme sports are free climbing, skydiving, surfing, and competitive motorsport (CM). Competitive motorsport is a very dangerous sporting activity which includes high speed driving and risky manoeuvres that can lead to negative outcomes such as injury risks or collision, for drivers and sometimes spectators (Tranter & Lowes, 2005). However, it is one of the most popular extreme sports in the world (Avery, Harper, & Ackroyd, 1990; Baur et al., 2006; Tranter & Warn, 2008; Turner & Richards, 2015).

In previous studies extreme sport participants have been explored from a risk-taking, negative perspective (Baker, Simon, Baker, & Simon, 2002; Laurendeau, 2008). Most researchers and theorists assume that individuals who undertake extreme sport have specific personality traits and motivations, which are related to a desire to consciously put their life at risk in the need of thrill and excitement (Brymer, 2010). The assumption underlying these portrayals is that individuals are risk seekers with 'deviant' traits, fascinated by the danger of the extreme sport (Brymer & Houge Mackenzie, 2017). Some of the dominant theories that discuss theoretical perspectives and are used to explain the abnormality of such behaviours are sensation seeking (Zuckerman, 1979, 2000) and masculinity theory (Connell, 1995, 2005). Through these approaches,

negative stereotypes can be developed which do not always reflect individuals' real feelings, thoughts and experiences (Brymer & Oades, 2009; Weber, 2001; Willig, 2008).

Brymer & Houge Mackenzie (2017) discuss more positive psychological explanations of the extreme sport population, which derived from the lived experiences of participants using theories of peak experience, peak performance and flow. Peak experiences, performance and flow are models of optimal human experiencing, which focus on intense joy, superior functioning and an intrinsically rewarding experience, respectively (Csikszentmihalyi, 1988; Kimiecik & Harris, 1996; Maslow, 1977; Privette, 1983). Despite their differences these concepts share important attributes, including absorption, valuing, joy, spontaneity, a sense of power, personal identity and involvement (Privette, 1983). Indeed, extreme sport athletes or participants are well-trained, prepared, self-aware and always careful (Pain & Pain, 2005). Studies have shown that extreme sport participants report deep, meaningful experiences, sense of freedom, intense feelings of connection and integration with the natural environment as well as peak experiences and flow, which sometimes led to lasting transformation for some participants (Brymer & Oades, 2009; Brymer & Schweitzer, 2012; Brymer & Schweitzer, 2013; Mackenzie, Hodge, & Boyes, 2013). Extreme sports can be associated with several positive psychological benefits (Brymer & Gray, 2010; Willig, 2008) such as courage and humility, the ability to manage fear and use it as a tool to gain greater understanding of themselves, being resourceful, adaptable and demonstrate a strong sense of reality and emotional control (Brymer, 2010;

Brymer & Schweitzer, 2012). These attitudes, cognitive and physical skills, such as resilience, inner and physical strength, are common and necessary among military personnel (Adler et al., 2015; Castro, Hoge, & Cox, 2006; McGurk et al., 2006). CM reflects similar qualities to the military, such as the dedication, the discipline, the adrenaline buzz, the emotional control, the competitiveness and the initiative. If veterans gained life satisfaction through armed forces experience, it is not surprising that CM will also provide satisfaction as it will fulfil those needs (which have been lost after leaving the service) in a civilian environment.

5.2 Research Rationale & Research Aims

Non-therapeutic approaches, such as NAT, WEPs, physical activities or extreme sport can help veterans re-shape their identity and enhance their self-esteem (Carless & Carless, 2014; Dietrich et al., 2015; Poulsen et al., 2015). One of the reasons putting in place alternative activities might be successful for physically and mentally traumatised veterans is that many of them need ways to prove they are still capable of new achievements and physical accomplishments (Burke & Utley, 2013; Carless & Carless, 2014; Hawkins & Lynne, 2011), something that cannot be achieves via conventional therapies (McFarland & Hubbard, 2010). Future research is needed to investigate the short- and long-term impact of alternative activities and the ways they can be used to facilitate veterans' transition process.

A review of the literature did not reveal any studies that evaluated the potential benefits of CM on military veterans. The purpose of this study is to

explore and evaluate the effectiveness of CM in having a positive impact on military veterans' well-being and providing rehabilitative benefits to the ones who have experienced traumatic physical (and psychological) injuries while serving.

5.3 Method

5.3.1 Study Design

This is a qualitative study based on semi-structured, in-depth interviews with British military veterans. Qualitative methods were used as they can provide insight into complex relations which can be critical in order to understand if and how competitive motorsport (as a physical activity intervention) may positively impact veterans' well-being and aid their transition to civilian life. Two psychometric measures were also used to better monitor participants' progress along with the follow-up interviews.

5.3.2 Participants

Fourteen individuals living in the UK were interviewed. Participants were all male British military veterans. Thirteen participants served in the British Army and one in the Royal Marines. The length of service varied between four and twenty-one years. The age range of participants was 25 to 51.

Participants had to be physically injured (minor or severe physical injuries) to take part. Twelve participants suffered severe physical injuries (amputees, brain injuries, back pain injuries) and two suffered minor yet permanent

physical injuries (knee pain)[15]. None of the participants had any form of therapy during this study. Please see Table 13 for participant characteristics in detail[16].

Five more participants, former members of KartForce who took part in a previous study (Hunt, 2014) agreed to provide a follow-up interview discussing potential long-term benefits and reasons why they have stopped karting. Demographics are not available.

Table 13 CM Participants' Demographics

Code Number	Age	Military Experience Military Service	Marital Status	Education	Profession	Physical Injury	Mental Health problems	Member of KartForce
P1	33	10 years Army	Cohabiting	DipHe Adult nursing	Casual worker	Yes	Yes (PTSD)	1 year and 8 months
P2	31	7 years Army	Single	BTEC	Full-time IT engineer	Yes	Yes (subjective self-report for anxiety)	2 years
P3	25	8 years Army	Single	GCSE Military Engineering	Not employed	Yes	No	1 year
P4	26	4 years Army	Single	GCSE	Not employed	Yes	No	7 months
P5	35	7 years Army	Married	GCSE	Not employed	Yes	Yes (PTSD)	2 years
P6	36	6 years Army	Married	GCSE	Not employed	Yes	Yes (PTSD, depression)	1 year and 6 months

[15] Most participants also suffered from mental health problems (some had an official diagnosis and some self-reported it). We acknowledge ill mental health as a key barrier of transition in civilian life and include it in the Data Analysis and Discussion, yet it was not part of the inclusion criteria for this study.

[16] Participants who took part in this study are noted as "PCM".

P7	36	14.5 years Army	Married	A-levels	Full-time	Yes	No	6 months
P8	27	8 years Army	Cohabiting	GCSE	Full-time Salesman	Yes	No	10 months
P9	33	6 years Army	Single	GCSE	Full-time	Yes	No	2 years
P10	32	6 years Royal Marines	Single	A-levels	Full-time Personal Trainer	Yes	Yes (subjective self-report for anxiety)	6 months
P11	39	19 years Army	Married	NVQ Level 5	Full-time Training Consultant	Yes	Yes (PTSD)	2 years and 4 months
P12	47	21 years Army	Single	BTech	Retired	Yes	Yes (Severe depression)	4 months
P13	41	19.5 years Army	Married	GSCE	Not employed	Yes	No	5 months
P14	51	20 years Army	Married	Secondary education	Self-employed	Yes	Yes (PTSD, Depression)	1 month

5.3.3 Interview protocol

Questions centred on participants' pre- and post-military experiences, the challenges during their transition to civilian life and ways CM (as a physical interventions) and KartForce (as a charity) enhanced their well-being and aid them to progress. A semi-structured interview protocol was developed from these areas of interest for both the first set of interviews and the follow-up interviews. Follow-up interviews aim to monitor the long-term impact of CM on participants' personal and professional lives. A copy of the interview protocol can be found in Appendix 5. During April 2017, feedback was sought from pilot interviews with two British veterans (potential research participants), and modifications made to the questions accordingly. Pilot interviews were not recorded and were not used as part of the analysis.

5.3.4 Psychometric Measures

Participants were assessed on psychometric measures (HADS & PCL-5) at 2 time points. Time point 1 was before the first set of interviews and time point 2 was at the 6 months follow-up interviews to monitor potential changes in symptoms of depression, anxiety and PTSD post-intervention. It is acknowledged that this is a small and non-representative sample and thus the purpose of the psychological measures was not to be used independently, but rather in conjunction with the qualitative data from the follow-up interviews. The validity and reliability of these measures were discussed in Section 2.4.3.

5.3.5 Procedure

Opportunity sampling was used during the process of recruiting participants, as the main aim of this research study was to conduct interviews with male military veterans who were part of KartForce and actively participating in racing events. The gatekeeper of KartForce has been contacted in order to be informed about the research and discuss future collaboration. The gatekeeper of KartForce agreed to approach potential participants (former and current members) and introduce the researcher to them as well as advertise the research on their website (https://www.kartforce.org/our-phd-study). The researcher attended several racing events to familiarise herself with the sport, meet potential participants, get involved in general discussions and informally inform individuals about the research. Participants who decided to take part in the research and share their experiences contacted the researcher directly.

Participants live all around the UK and meet in a different location each time, based on the racing events KartForce organises. That is why interviews were scheduled accordingly, to accommodate the participants. Twelve interviews and five follow-ups were conducted face-to-face. Some in the racetrack facilities, where the racing events were organised. A seminar room was booked in the facilities in advance from the gatekeeper in order to conduct the interviews. Interviews were scheduled either during long breaks (more than one hour) or after the racing events. The decisions for scheduling the interviews were made after agreement with the participants depending on what was more convenient for them. Some interviews were conducted in different locations across the UK. The researcher contacted the local libraries in advance to inform the person in charge and request a quiet place to conduct the interviews.

Two interviews and five follow-ups were conducted over the phone. Participants were already aware about the study and received the relevant documents (Information Sheet, Consent Form, demographics, questionnaires) via an email. For all phone interviews the researcher used a pay as you go SIM card to avoid using her personal phone number.

During the interviews:

The researcher communicated the interview questions ahead of time to participants, along with a general introduction about the study. Participants were requested to read the information sheet and the consent form, and time was allowed for the participants to ask relevant questions about the study.

Issues of anonymity and confidentiality were explained to them, as were the reasons for using a Dictaphone or ACR (a call recorder app for phone interviews) to record the interview (in order to enable a detailed transcription to be made). Participants were informed that they could withdraw from the study at any point without further consequences. Participants were requested to sign the consent form before the beginning of the interview. Their name was replaced by a code number and any names mentioned in the interview have been changed. Follow-up interviews were conducted 6 months after the first set of interviews. Ten follow-up interviews were conducted.

The first set of interviews was conducted between May 2017 and February 2018. The follow-up interviews were conducted six months after the first set of interviews between November 2017 and September 2018.

The interviews were carried out in English and transcribed by the researcher. They varied in length from approximately 30 minutes to 90 minutes for the first set of interviews, and 10 minutes to 20 minutes for the follow-up interviews.

5.4 Data Analysis: Qualitative Data

5.4.1 Results: 1st set of interviews

Analysis of the interviews yielded two key themes. These were: (1) *Competitive Motorsport as an intervention* and (2) *Benefits of Competitive Motorsport* Themes and sub-themes are presented in Table 14 Themes Chapter 5.

Table 14 Themes Chapter 5

Themes	Sub-themes
Competitive Motorsport as an intervention	*(i) Familiar Environment* *(ii) Team Spirit* *(iii) Adrenaline Rush* *(iv) Competition* *(v) Equality*
Benefits of Competitive Motorsport	*(i) Psychological Benefits* *(ii) Physical Benefits* *(iii) Social Reconnection*

5.4.1.1 Competitive Motorsport as an intervention

(i) Familiar Environment

Participants argued that regardless of their experience or ability to drive go-karts or racing cars, they felt that they operated in a similar environment to the military. Participants identified similarities between CM and military, arguing that the unique aspect of the sport was not just the racing itself, but many things involved, such as briefings, preparation, practice and tactics.

PCM4: *"… with karting there's always people there. You kind of have to work as a team, which brings you back to the Army, really, being a team. So, yeah, that's the biggest thing I like".*

Participants stated that racing was an inspiring alternative resource which increased their sense of belonging and helped them find a sense of purpose in civilian life. They explained that one of the reasons they were feeling their transition to civilian life was challenging was their inability to adapt and use

the knowledge and transferable skills they had developed while serving in the military.

PCM5: *"…Because some of the races we do like are 24-hour, so you need to... your leadership skills, planning skills but you also need to... your communication skills to make sure that the next guy knows all of the plan and the information […] enjoy the responsibility of it and it's kind nice to be given back that bit of responsibility"*.

Veterans' involvement in CM was an opportunity to start using and refining their skills, not only to their benefit as individual racing drivers, but also optimally contribute to the achievement of the team objectives.

(ii) Team Spirit

Participants reported that they had strong sense of team spirit, which was something they could not easily find among civilians. They highlighted that one of the first things that inspired them to participate in CM was to be part of a team again; being around like-minded individuals who share similar experiences and are bound together by common values and beliefs.

PCM8: "*I think it's having that band of brothers sort of thing again. We're all in the same boat. We all enjoy the karting. We've all been places, seen stuff and that. It's... Yeah, it's like being in the Army again but not having someone micro-manage every single aspect of your day*".

Participants explained that team bonding happened instantly and naturally, something that helped them to feel more confident and comfortable to build

new friendships, communicate, share ideas and offer peer support and guidance.

(iii) Adrenaline Rush

Participants argued that another reason that makes CM a unique experience for them, was that they can replicate similar emotions to when they were participating in other risky activities while serving, such as military training or combat.

PCM2: "*Now I'm quite good at karting and it's an adrenaline rush and it's that competitive edge. Like I've had a few crashes and it really hurts but, you know, you push yourself to the limit […] it's the thrill, I think…"*

Participants acknowledged that racing can be defined as a high-risk sport. For them is a way to generate positive emotions, such as pump of adrenaline and the thrill of risk-taking, even though sometimes they put their physical health on the line (e.g., be in pain, minor accidents in the racetrack).

(iv) Competition

Participants also argued that another significant element of racing is its competitive nature. They explained that they feed on the healthy competition and self-respect that comes with being able to overcome the hurdles of each racing event.

PCM10: "*It's competitive. I like beating people… I couldn't go to a track and just go around by myself. I'd have to have somebody else there. So, getting in the car... I'm starting to race cars now as well. And, yeah, that's it, really, that you very much live in the moment. So, there's nothing else that really matters*"

Participants acknowledged that being able to compete is what gives them the opportunity to gain exciting experiences again, set the bar higher every time, find a purpose and focus on the goals that they strive to accomplish.

(v) Equality

Another unique element of CM that participants acknowledged comparing to other sport, is that it provides equality of opportunity for people with minor and severe disabilities. The vehicles that veterans use are specially adapted where necessary to enable the ones who have lost limbs to drive them. Participants explained that in other sports, such as basketball, you have to compete with individuals who have the same form of disability in order to get a fair play; for example, a game between lower limb amputees and upper limb amputees would not be fair even though both parties are amputees, let alone a game competing with able-bodied individuals.

PCM1: *"I tried wheelchair basketball. A bunch of other disabled people and then there is fully able-bodied people playing. And I'm like, I'm competing against them, but I'm still handicapped. I'm still not on the same level, because I know physically, they're better than me…"*

What was mostly highlighted among all participants was the great advantage to be able to compete not only with individuals who have a different physical impairment, but also with able-bodied individuals.

PCM11: *"…definitely I think that motorsport is good for people at all levels, no matter what their level of injury is, whether it be extremely physical or mental health. It puts everybody on a level playing field. So, we're out there now*

competing against guys that have got no injuries or mental health issues but they're no better than us […] it's not like going out and playing a football match, 11 people with injuries against 11 people without injuries. It would be totally unfair. This makes everything fairer"

That is because there is specialized equipment, for example, there are various vehicle adaptation solutions suitable for amputees that give an equal opportunity to everyone. Participants argued that equality and fair play was one of the main factors which boosted their confidence and self-esteem and made racing the most preferable option.

5.4.1.2 The benefits of CM

(i) Psychological Benefits

Participants highlighted that through their participation in competitive motorsport, they managed to get and remain motivated after leaving the military. One of the most positive effects was having a sense of purpose again and be able to set goals not only to improve their performance and skills relating to racing, but also their self-esteem and confidence. Participants also argued that they feel happier and more emotionally stable, something that increased self-motivation in their daily life.

PCM11: *"It makes me motivated and happy, but it also makes me nervous but positive nervousness 'cos I want to do well…"*

Some participants argued that when they left the military, they were dependent on family members, as they were feeling insecure to undertake responsibilities or do things on their own. Through CM they managed to

overcome their insecurities, be able to control and manage their feelings better and cope with everyday challenges in civilian life. These improvements had a positive impact on their psychological well-being and helped them become more autonomous and independent.

PCM6: *"I can control myself. I have quite a lot of incidents where I can't but, yeah, it's managed better now than it was… I actually want to go karting because I'm getting quicker now in my racing […] it gives you purpose. It gives you something to focus on […] I have a hobby to do and it's getting me out of the house as well. I'm a lot happier for it rather than sat in front of the TV or looking at the walls, like I used to do"*

Some participants decided to start racing with cars and started to pursue a professional career as racing drivers with Team Brit. They argued that competing on a professional level can be stressful but having a strong sense of purpose was what helped them overcome their fears, enabled them to face challenges and move forward.

PCM5: *"I've stepped up and I'm part of Team Brit as well… If you asked me a couple of years ago, it's something I could never have imagined I would be able to do. I would never imagine I would have the ability to drive a race car, let alone deal with the pressure that comes with it…"*

The impact of competitive motorsport on participants' well-being was positive, as it affected them directly and indirectly. Through their participation they managed progress and steadily achieved inner peace and psychological healing. This kind of transformation was evident in participants' accounts, as

they moved from a negative story of loss and hopelessness to a more positive, hopeful story.

(ii) Physical Benefits

Participants highlighted how physically active and motivated they used to be before and during their service, something that stopped after leaving the military. Through racing they managed to become physically active again and make their civilian lives more exciting. The fact that they had to challenge themselves while racing, had a positive impact on their health behaviours and self-esteem.

PCM12: *"The active side I am enjoying lots, yeah […] I've always been an active person, so for me to do this is a great challenge, you know, and I enjoy challenges. So, this has given me… boosted my confidence…"*

CM opened some new doorways in participants' heads. Apart from the psychological benefits associated with racing, participants were able to come in terms with their disability and learn how to manage their pain levels. A positive consequence was that participants started looking after themselves, aiming to improve their body image. This included not only their desire to become better in racing, but also to exercise in order to improve their physical health and appearance.

PCM6: *"…I started karting with KartForce, I've gone from 13 and a half stone down to 11 stone... It has made me conscious of my weight [...] I'm managing my pain levels a lot more now. So, obviously, with the weight loss, that's helped*

relieving the pressure off my knees. And it makes me feel a bit better with myself […] I feel like I have a bit more energy…"

Overall, participants argued that CM helped them understand that there is life after the military. Physical activity and specifically racing became the steppingstone, which helped them to improve holistically, mentally and physically, and move forward into building a new life.

PCM13: *"I mean, I think the last few weeks have been a bit of an eye-opener for me […] I'm aching now but I feel good for it 'cos you know that you've done something […] It feels good. You know, it releases your endorphins and you feel great about yourself"*

Participants recognised the excessive rewards gained through their participation in CM. Evident in their accounts is a sense of immersion in this activity, which led to embodied acts of doing, experiencing joy and distraction from troubling thoughts.

(iii) Social Reconnection

Participants discussed the positive impact that their involvement in CM had in their social life. It helped them to relax, develop new competences and improve their social and interpersonal skills in civilian life. The fellowship that participants had the opportunity to develop and the team nature of this sport contributed to the bonding between participants and lifted them out of the isolation that they often experience after leaving the military.

PCM7: *"I think it's the involvement with the group of people doing something you enjoy is what gravitates people to those activities […] I think is key to why people enjoy it. It's not I'm playing this because it's good for my back...It's because you get benefit of the social interaction…"*

The familiarity to the military environment contributed to participants' transition to civilian life and enabled them to be together with other veterans in a 'sheltered area' in a non-clinical setting. This was the key factor that allowed participants to progress, not only as individuals but also as part of the society, to feel comfortable and safe to express themselves and reconnect with others.

PCM5: *"I think it is similar to the Army. You know, you've got that camaraderie and kind of the bond between... 'cos, you know, you're in a team and, you know, you all wanna work together to perform as effectively as possible […] it's the way you can speak to each other. You know, the way soldiers speak to each other, if a civilian was listening, you'd think that they hated each other when they're probably best mates… It's just a combination of things. It's being relaxed and not having to worry about what people think and stuff like that"*

For participants CM was the pathway to gain inner peace and embrace their disability or mental health issues. Accepting these was not a fundamental part of their being, but rather a way to increase their confidence and self-esteem and start shaping their new identity. A positive consequence of their personal development was participants' ability to adapt faster in civilian society,

establish a more open communication and socialise not only with other ex-servicemen, but civilians as well.

5.4.2 Results: Processing & Reflection (Follow-up interviews)

Participants argued that through their long-term participation in CM they acknowledged a continuous and steady improvement in their mental and physical health. Racing events are always a unique and positive experience for participants, which give them purpose to strive to become better each time. Participants explained that as the time passes, they feel more independent, confident and comfortable to take initiative, undertake new responsibilities and do things by themselves without needing the support of their family or friends. They argued that they generally feel happier and more energetic in their everyday life. This continuous motivation, which initially was centred in racing itself, now became part of their daily life and a source of inspiration and purpose, which positively affected their transition to civilian life.

PCM5: *"You can't think about anything else while racing, you can't think of the past not even the future, you are just in that moment – so it is good to just re focus your mind, and you know you don't worry about anything […] 100%, absolutely it has helped me... Motorsport is fantastic for keeping me on track"*

Participants stated that being able to control their negative thoughts and feelings had a positive impact on their mental health, helping them improve the way they cope with challenges in their personal and professional life. Some participants reported that their relationships with family and friends have been improved, as they are more able to rationalise negative situations, establish

open and honest communication and re-build trust. Other participants stated that they were able to find and maintain a job, having the opportunity to build a new career and progress.

PCM6: *"I mean, before KartForce I did nothing I was lazy, I was at home just sitting there, but now I have joined KartForce and I can't wait for races, it gives you motivation, it gives you a big buzz […] I mean because of all this as well it brought me down to a level where I can see my daughter again, I don't think I will ever be 100% but …rather than being down here, just below the middle, I am kinda between middle and top again…"*

Due to life circumstances or excessive workload some participants had to reduce the number of racing events or completely stop participating. Nevertheless, it was highlighted that CM was the main activity which '*opened a door*' to their future and enabled them to effectively manage their transition to civilian life and fit into society.

PCM5 (2nd follow-up group): *"In the past two years, unfortunately due to work I had to reduce the amount of karting I do… Kartforce is still a fantastic charity and organisation… I do get out on track when possible and when I do get out on track it does ignite that passion. It does reignite the competitiveness. I do have the same feelings of being on a level playing field with other drivers, the camaraderie between me and my teammates… It's like we haven't been apart, we just picked up where we left off…"*

Participants explained that a positive consequence of the various psychological and physical benefits they have gained through CM, was having the ability not

only to understand themselves and explore their future options in their personal but also in professional life. Participants argued that they felt more confident to undertake new responsibilities, successfully maintain a job, experiment with other activities and start a new career.

PCM1 (2nd follow-up group): *"I've been in motorsport all my life, so that's why I went to KartForce, 'cause this was what I knew and what I loved…and then basically I took out golf […] I am the first disabled amputee to have a play on the EuroPro Tour. I switched all my focus on that because I was quite good at it… I didn't have the time to go karting anymore, so the main reason was just time for me…"*

Participants acknowledged that CM is not an activity that would benefit all military veterans who have suffered mild or severe psychological or physical trauma. However, they would definitely recommend it to fellow veterans. Participants highlighted that racing has short- and long-term benefits, which are achieved effortlessly through co-operation, socialisation and fun, something that appears to be the greatest advantage compering to conventional therapies.

PCM3 (2nd follow-up group): *"Sport can be therapy without actually being therapy… Sometimes guys are reluctant to admit they've got a problem, or they're reluctant to get help or reluctant to go therapy because it's very official or it's very clinical. Sport can be therapy without them even realising it, without them even thinking that it is therapy…"*

A combination of key factors enabled participants to progress in a personal level, improve their interpersonal relationships and re-adjust to civilian life. On the one hand, it is racing itself, which is the type of physical activity that brings back familiar elements such as adrenaline rush and competition. On the other hand, it is the social aspect of the sport, which brings together veterans, encourages the team spirit, allows them to express themselves in a healthy way and helps them improve and establish effective communication with both ex-military personnel and civilians.

5.5 Results: Psychometric Measures

Participants were assessed on psychometric measures (HADS and PCL-5) at two time points. Time point 1 was before the first set of interviews and time point 2 was after one week of the follow-up interviews to monitor potential changes in symptoms of depression, anxiety and PTSD post-intervention and assess the efficacy of the intervention. It is acknowledged that this is a small and non-representative sample and thus the purpose of the psychological measures was not to be used independently, but rather in conjunction with the qualitative data from the follow-up interviews. Participants who did not take part in the follow-up interviews and did not complete the questionnaires were not included in the analysis.

Initially, a Shapiro-Wilk test was conducted in SPSS (IBM SPSS, 2016) and results indicated a non-significant departure from normality ($p > .05$); more specifically, for depression pre: $W(10) = 0.97$, $p = 0.92$, post: $W(10) = 0.95$, $p =$

0.77, for anxiety pre: W(10) = 0.93, *p* = 0.51, post: W(10) = 0.93, *p* = 0.46, and PTSD pre: W(10) = 0.92, *p* = 0.42, post: W(10) = 0.94, *p* = 0.65.

A paired-sample t-test was then conducted in SPSS (IBM SPSS, 2016) to compare the pre- and post-test scores of depression, anxiety and PTSD and better monitor potential changes after a 6-month participation in CM (Table 15).

Table 15 T-Test CM

	Pre-test			Post-test		Paired Samples Test		
	N	Mean	Std. Deviation	Mean	Std. Deviation	t	df	Sig. (2-tailed
HADS D	10	7.70	3.683	4.00	2.494	7.150	9	.000
HADS A	10	10.00	5.578	3.50	2.273	5.483	9	.000
PCL-5	10	39.30	23.533	27.20	16.765	3.779	9	.004

The results from (i) the depression pre-test (*M* = 7.70, *SD* = 3.68) and post-test (*M* = 4.00, *SD* = 2.49), (ii) anxiety pre-test (*M* = 10.0, *SD* = 5.57) and post-test (*M* = 3.50, *SD* = 2.27) and (iii) PTSD pre-test (*M* = 39.3, *SD* = 23.5) and post-test (*M* = 27.2, *SD* = 16.7), indicate that long-term participation in CM was indeed beneficial, (i) *t* (9) = 7.15, *p* = 0.000, (ii) *t* (9) = 5.48, *p* = 0.000 and (iii) *t* (9) = 3.77, *p* = 0.004, respectively. These results are in line with the data from the follow-up interviews, indicating that overall, CM benefited participants'

psychological well-being. Of note here, even though participants did not attend any other form of therapy during their 6-month participation in CM, this positive change can be a combination of participation and a natural occurrence over time.

5.6 Discussion

The purpose of the present study was to investigate the potential positive impact of CM on the subjective and psychological well-being of physically and mentally traumatised military veterans and broaden current understanding on this area. Current results indicate that the experience of participating in CM was overwhelmingly positive in the short- and long-term. This study identifies the various benefits on veterans' well-being and quality of life, including psychological and physical benefits. The key elements of CM as a sport, which distinguished it among others were the (i) familiar environment and structure (ii) sense of belonging and strong team spirit (iii) adrenaline rush and healthy competition (iv) equal opportunities to compete regardless of the type of disability. These findings are in line with research on civilian and military male population and masculinity, suggesting that in the traditional masculinity-health relationship, masculinity can have a positive impact on health behaviours, such as participating in various forms of physical activities (Connell, 1995; Manderson & Peake, 2005; Paluska & Schwenk, 2000; Smith, 2013; Wedgwood, 2009). More specifically, the ex-military population tends to be motivated by physical activity that may involve high levels of adrenaline, competition and achievement. Indeed, recent studies which investigate

inclusive activities, such as sport, have been found to be of particular benefit to service personnel and veterans (Caddick & Smith, 2014; Carless et al., 2013; Hawkins & Lynne, 2011; Messinger, 2010). Current results are in line with the theories of peak experience, performance and flow (Brymer & Houge Mackenzie, 2017; Brymer & Schweitzer, 2013; Privette, 1983), suggesting that extreme sports can transcend and transform daily experiences and facilitate positive psychological experiences. As a result this can inspire and motivate individuals' in the long-term and not just offer short-term thrills through risk taking as most traditional theories suggest (Brymer & Houge Mackenzie, 2017). As discussed in Chapter 3, despite available mental health services for veterans, many of them are not benefiting from these services. There is a need for novel interventions to reach more veterans the system currently does, regardless of whether this is due to desirability, availability or perceived efficacy of the interventions and treatments offered (Dietrich et al., 2015; Hoge et al., 2004).

Participation in CM created a new path on veterans' lives by facilitating positive experiences. Most of them did not have previous experience racing with go-karts or cars, yet, from day one felt part of a familiar environment. Participation in CM allowed veterans to draw upon pre-existing personal resources and use their past military experience and transferable skills to reach their goals. Such similarities between the military and team sport was also acknowledged as a significant factor in veterans' recovery in other studies (Burke & Utley, 2013). Excitement for replicating emotions of military training or combat was well-reported among the findings. The procedure before and

after a race, such as briefing, deciding on an action plan for the race and establishing a performance improvement plan with fellow veterans, created a structured and familiar environment similar to the military. This enhanced veterans' confidence and allowed them to become more independent on doing things by themselves; for example, attending racing events without their spouse/partner or travelling long distances alone depending on the location of the racing events. Similar studies also indicate that injured veterans used different types of physical activity as a form of active coping, to be proactive and do things to enhance their own well-being and better negotiate their transition within society (Brittain & Green, 2012; Burke & Utley, 2013). Veterans were able to combine their military knowledge and transferable skills in a novel setting (i.e., racing), but also use this strong sense of achievement to improve their personal everyday life. Overall, this enhanced feelings of confidence and self-efficacy. Current findings match those of other studies suggesting that the participation in physical activities and team sport provided a sense accomplishment not only for injured/disabled veterans but also the ones who suffered from mental health problems (Brittain & Green, 2012; Dustin et al., 2011; Hawkins & Lynne, 2011; Hyer et al., 1996).

The unique bond among veterans and the value of sport in building team spirit and camaraderie are well-outlined in the current findings as well as in a number of large research publications in military (Kirke, 2010; MacCoun & Hix, 2010; Salo, 2006) and civilian populations (Andersen et al., 2018; Cotterill, 2012; Lafferty et al., 2017; Falcão et al., 2015). These key elements increased veterans' sense of belonging self-esteem, social and communication skills.

Veterans were able to re-establish their sense of self and reduce feelings of loneliness and isolation. The socialisation with peers in a non-clinical environment also played a key role in veterans' continuous development. This positive reinforcement had a direct impact on veterans' personal and social life; feeling better with who they were or could become helped them be calmer and effectively manage their personal relationships with their female spouses, partners, family and friends. Current findings are in line with other studies which also explore the positive impact of sport on physically and mentally traumatised veterans' subjective and psychological well-being (Burke & Utley, 2013; Caddick & Smith, 2014). Social support is a vital component of veterans' experiences of participating in CM and very well-outlined in this study, too. The importance of teamwork and the practical and emotional support that veterans offered to each other made the difference in achieving their goals, such as becoming better or start racing cars professionally.

Veterans fully endorsed the value of CM. Adrenaline rush is a key aspect of CM (Turner & Richards, 2015) and competition is central among sport (Zeigler & Shilbury, 2012). These two elements were deeply appreciated by veterans and essentially, they were the core aspects of this sport that distinguished it from other team sport or activities. Significant improvements in physical health were reported. Veterans managed to see beyond their injuries and mental health problems and understand what they could still achieve. They started taking care of themselves, reducing or stopping alcohol consumption and setting goals to exercise more to become fitter and stronger and eating healthier to lose weight. Developing a positive attitude towards their body

image allowed veterans to be more comfortable with their disability or amputation specifically and generally with who they are. It reduced stress levels, boosted their self-esteem and enhanced motivation for rehabilitation. These findings are in line with findings from similar studies, emphasising the benefits of participation in sport in creating a positive sense of self-identity as well as reconstructing a positive self-image post injury (Burke & Utley, 2013; Hawkins & Lynne, 2011). Along with these positive changes, increased willingness, inner motivation and self-determination were well-documented in this study. Similar studies also suggest that through sport veterans can adapt to their disability or mental health problems by putting their lives into perspective and re-constituting their self-concept in a positive way (Carless et al., 2013; Dustin et al., 2011).

Racing events gave the opportunity for veterans to compete and socialise not only with fellow veterans but with civilian as well. This increased veterans' determination and inner strength and helped them set new goals not only regarding the sport but also their life overall. It is well-outlined in the literature that social interactions can have profound 'therapeutic' implications and the lack of social support has consistently been identified as a relevant factor in the development and maintenance of mental health problems, such as PTSD (Brancu et al., 2014; Price et al., 2013). Veterans who received both tangible and intangible support (e.g., caring, empathy, advice, guidance), as opposed to assistance in tasks respond better to treatment efforts (Price et al., 2013). The principle of equality and inclusion was central among findings. The go-karts and cars have been adapted for use by disabled drivers and that made the

difference. It gave the opportunity to veterans with severe disabilities (e.g., lower-body amputees) to take part and have equal competition not only with fellow veterans who had minor physical injuries but also able-bodied individuals. In line with other similar studies results indicate that sport can enable veterans to discover and acknowledge their limitations, while, at the same time, show them what they can still achieve (Brittain & Green, 2012). Veterans who enjoyed the sport as a hobby and discovered their hidden talent, had the opportunity to evolve and perform at a professional level. Undertaking new duties and responsibilities empowered and helped them develop as individuals. Apart from being occupied with training, veterans were able to improve their interpersonal and negotiation skills, learn how to promote themselves, interact with civilians in a professional level. Taking responsibility for their actions gave veterans the satisfaction and contentment of knowing that they can re-build a productive life in the civilian world. These results are in line with similar studies, which indicated that sport broadened veterans' horizons and provided veterans with a valued goal to strive for by facilitating the positive experience of inner strength and determination (Burke & Utley, 2013; Carless et al., 2013, 2014).

Through their six-month participation in CM and being part of a group (i.e. KartForce), findings show that there was a significant improvement on veterans' social well-being and mental health status with depression, anxiety and PTSD symptoms being decreased. These findings match those of other studies suggesting the positive and symptom-reducing effects of physical activities, which helped veterans to better engage with 'here and now',

achieving a sense of relaxation (Crawford, 2016; Dustin et al., 2011; Greer & Vin-Raviv, 2019; Otter & Currie, 2004). It was also reported that veterans would be more than excited to continue participating as it increased their sense of achievement and had a direct impact on their personal and professional life. Opposed to similar studies, the current study highlights the need to identify not only the direct (i.e., subjective well-being) but also the indirect impact that participation in such activities may have on all aspects of veterans' life. Some veterans had to stop racing only because they managed to evolve their career effectively and they did not have the time to attend racing events. It is important to note here the significance of the group cohesion in the charity. The individuals who stopped racing highlighted that they knew they could always count on the team for advice and support. Recent studies which explore the potential impact of physical activity or sport on veterans' well-being (Caddick & Smith, 2014) usually do it by setting a specific period of time for short-term intervention, for example wilderness experience programmes (Dietrich et al., 2015). This study suggests that apart from the type of sport, the sense of belonging in a team (e.g., KartForce) by actively participating in racing events or not, played a crucial part on veterans' positive holistic development.

Limitations & Future Research

Physical activity and sport may play an important role as a simple, inexpensive and effective intervention for the physically and psychologically traumatised military population. In line with similar studies on ex-military personnel, this study also indicates the multiple positive effects of physical activity by adding

into the existing literature. The current findings are in line with previous studies that there is a need to provide a wider range of activities for veterans than just psychological therapy, through novel activities such as sport. Much has been elucidated about the relationship between physical activity and veterans' mental and physical health and despite of this being a continuation of the first study, to the best of our knowledge, to explore the benefits of CM, there are still many missing components of understanding that could be addressed with randomised controlled studies.

The study findings are based on a small number of British physically and mentally traumatised male veterans who participated in CM, as part of a charity, and cannot be generalised across all ex-military personnel. All participants served in the Army, apart from one who served in the Royal Marines and this limits our understanding on how CM could benefit ex-Navy or ex-Royal Air Force personnel. Participants had different types of physical injuries as well as different types of mental health problems, from minor to severe. This raises the question of whether CM can be beneficial for a wide audience or if it only benefits a select few. The data of this study was a snapshot of a 6-month participation period; not all participants had started racing at the same time and not all of them were on the same level. Further qualitative research is needed, which will include longitudinal interviewing, timelining, vignettes, for a long period of time in order to investigate not only the direct inner benefits but also the impact on veterans' personal and professional life in the long-term. Future research should focus on obtaining a larger more homogenous sample in order to isolate specific groups of ex-

military personnel and effectively indicate for which group CM is most beneficial; for example only lower body amputees, only female veterans, only veterans who suffered from a mental health problem but they are not physically injured and the opposite. The psychometric measures were used only to better support the qualitative data and even though a positive change was demonstrated on participants' mental health, this is not an indicator that only the participation in CM led to this change. There is a need for quantitative or mixed method research or controlled studies to determine whether these positive changes are a result of CM or if a combination of many different factors facilitate a positive change; for example, exploring if there is an optimal intensity and duration of physical activity needed to produce improvements in emotional well-being as well as how and when physical activity can be incorporated into a therapeutic plan, which includes medication or conventional therapy. Finally, future research should identify the factors that could motivate veterans and promote diversity in offerings, such as activities with family as an aspect of bonding, to increase uptake of engagement in such activities and facilitate their transition to civilian life.

Implications for Practice

This study showed that participants discovered KartForce and CM mostly through friends. As discussed in Chapter 3, there is a lack of a holistic approach that involves various opportunities and alternatives activities and allows ex-military personnel to choose or combine activities and programmes that best accommodate their needs. Resettlement programmes and clinicians who work

with the ex-military population should be well-informed and be able to provide options and develop tailored plans to facilitate transition to civilian life. Clinical interventions can promote involvement in safe, affordable and exciting physical activities or team sport, which will take into account relevant individual characteristics, such as physical limitations, coping styles or severity of symptoms and accomplish adaptive aims for the veterans. Future research on this area should identify the long-term economic and cost-benefit implications of recommending physical activity/sport, which will be particularly useful for the improvement on the rehabilitation and resettlement plans of the military and NHS.

5.7 Conclusions

This study indicates that participation in CM had a significantly positive impact on veterans. Many benefits were reported. Veterans were able to develop a holistic self-care plan, enhancing their physical health, psychological and social well-being. The similarities between the procedures and values of CM and military training, such as team spirit, adrenaline rush and competition, were key elements of the sport which allowed veterans to feel comfortable, demonstrating positive attitude to change. Both CM as a sport and group cohesion among the members of the charity, directly benefited veterans in their personal and professional life. The importance of socialising in a non-clinical environment and competing with fellow veterans who had severe or minor physical injuries, but also able-bodied civilians was highlighted among the findings. Results also show an increase in body image satisfaction and

healthy eating and exercise attitudes. Veterans were able to understand their strengths, improve their weaknesses and start re-shaping an identity as part of the civilian society. The decreased depression, anxiety and PTSD symptoms as well as enhanced self-esteem, confidence and great sense of achievement were well-outlined in this study. Since physical activity and sport are included among the growing research on alternative interventions to support military veterans, they deserve serious consideration as part of the treatment regimens to improve veterans' mental and physical health and facilitate their transition to civilian life.

Chapter 6: Family Reintegration - Experiences & Insights of British Military Veterans and their female Spouses/Partners

6.1 Introduction

6.1.1 Family Reintegration: Military Veterans

Over the past decade, studies have examined transition challenges from military to civilian life, focusing more on the mental and physical health difficulties experienced by UK (Fear et al., 2010; Stevelink et al., 2018) and US military veterans (Pietrzak et al., 2012). Research shows that potential factors which may protect individuals can be having a social network of friends and family, higher levels of education, having a personal confidant, pet ownership and spirituality (Adams et al., 2004; Parslow et al., 2005; Victor et al., 2005). Yet research on family reintegration difficulties and the consequences veterans' mental or physical health may have on spouses or intimate partners during transition to civilian life remains limited in the UK (CSJ/FiMT, 2016; Samele, 2013). As discussed in Chapter 1 (section 1.2.1/iv), the MoD recognises the importance of the family during veterans' transition and resettlement, as a key factor for a successful new civilian life (KCMG, 2016). Even though the Armed Forces covenant discuss all the statutory services that families in the UK are expected to access (e.g., healthcare, education, housing), it seems that only voluntary services provide support for their emotional needs (Johnson & Murariu, 2015; Samele, 2013). One major difficulty family members, particularly spouses, may face when the service member leaves the military, is their re-adjustment to the civilian attitudes and behaviours. Over the long

term, many military families successfully navigate the challenges of transition by engaging in and promoting their community and family reintegration (Resnik et al., 2012). Even though couples have diverse reintegration experiences, challenges can increase during family reintegration either when veterans suffered physical injuries or developed mental health problems (and thus require additional support) or when there are pre-existing couple and family vulnerabilities (Sayers, 2011). In this context, there are numerous co-occurring practical and emotional difficulties which could put strain on the couple, including marital discord, problems with negotiating family roles, child behavioural challenges, employment issues, financial hardship, relocation or ill mental and physical health. The couple will need to re-negotiate basic household routines, strengthen joint problem-solving and decision-making abilities, and re-establish support networks (Faber et al., 2008). For military families, reintegration and transition from the military to civilian environment can be experienced as a reverse culture shock, leading to anxiety, uncertainty and stress related to the unknown (Thomas, 2018). This may require development of a set of new skills and understanding to re-adjust and move forward.

6.1.2 Family Reintegration: Veterans' Spouses/Partners

Studies have shown that spouses of veterans who suffer from common mental disorders, such as depression, anxiety, PTSD, TBI, experienced increased levels of emotional distress, which may have a detrimental effect on the relationship quality (King et al., 2006), decreasing the couple's capacity to communicate (Gerlock et al., 2014). Secondary traumatic stress is also common among

spouses/partners of veterans with ill mental health (Ahmadi et al., 2011). Research indicates that spouses/partners are at higher risk of gradually becoming enmeshed in their husbands'/partners' pathology and experience similar symptoms (Dirkzwager et al., 2005; Goff et al., 2009; Manguno-Mire et al., 2007; Arzi et al., 2000). Overall, psychological distress, burden, sleeping and somatic problems and higher rates of marital maladjustment and sexual dysfunction have been reported among spouses and female partners of combat veterans who suffered from PTSD or other mental health issues that interfere with daily functioning (Norris et al., 2018).

A recent study explored the lived experience of partners of UK veterans with military-related PTSD (Murphy et al., 2017). Results suggested that there was an inequality in the relationship, with the focus on veterans' needs. Consequently, spouses experienced feelings of isolation and sadness, loss of their own identity and suppression of their true self by avoiding communication and direct conflict. The importance of tailored support and the opportunity to share their experiences with peers and professionals were highlighted as key factors that benefited spouses. Similar results were revealed from other studies, which compared the experiences of veterans who suffered from PTSD and their spouses with veterans without PTSD (Klarić et al., 2009), or analysed self-report psychometric surveys administered to 181 female spouses of combat veterans (Macdonell et al., 2014). Indeed, spouses whose husbands were experiencing PTSD, reported higher levels of caregiver distress and burnout, including hypervigilance, intimacy problems, exhaustion, social isolation, or overall low marital or life satisfaction. Research also demonstrates

numerous family and relational demands and their negative implications experienced within the couple where one partner suffers from ill physical or mental health. These include, low intimacy, expressiveness, self-disclosure (Riggs et al., 1998), decreased cohesion and increased conflict (Solomon et al., 1992). Overall, poor communication and emotional distance can steadily increase levels of anger, feelings of isolation, sadness and stress (Mansfield et al., 2014). These factors can have a long-term negative impact on relationship adjustment (Erbes et. al., 2012) and overall relationship quality (Miller et al., 2013).

Caregiver stress is an additional responsibility experienced by spouses of veterans who suffer from mild or severe ill mental and physical health. Studies suggest that caregiving spouses are challenged to maintain a sense of self and their independence and autonomy. The responsibility of caring for the physically or mentally injured husband can consume spouses'/partners' physical and emotional resources and decrease the ability to maintain a sense of self and control over personal space. Yet, results revealed a sense of empowerment from the experience of supporting their husbands with their moral commitment ruling out the possibility of separation/divorce (Dekel et al., 2005). Studies indicate that involving spouses/partners in veterans treatment may improve veterans' treatment outcomes (Monson et al., 2012) and improvement on relationship quality can potentially reduce the severity of PTSD symptoms (Taft et al., 2011). Nevertheless, in some cases when spouses/partners act as carers by undertaking a supportive role in their

husband's/partner's treatment can be compromising for their own mental health and emotional well-being (Verdeli et al., 2011).

Studies report individual capabilities, resources and behaviours utilised by spouses in their efforts to successfully cope with veterans' mental or physical needs and demands. Overall, positive spouses'/partners' perceptions of meaningfulness of service and pride of their husbands'/partners' military mission and service increased their inner strength and resilience and had a positive impact on the way they identified themselves as a family (Bergmann et al., 2014; Runge et al., 2014). Self-disclosure, empathy, patience and tolerance have been found to play a mediating role in buffering negative symptoms of veteran PTSD for spouses (Erbes et al., 2011). The acknowledgement of the difficulties associated with veterans' transition issued and made sense of them, especially those associated with mental or physical health issues, was found to have potential protective impact on spouses (Renshaw & Campbell, 2011; Renshaw & Caska, 2012). Relational and interpersonal dynamics also contribute to the ways a family can cope as a unit, and tackle challenges during transition. Factors that facilitate and increase family capabilities include marital intimacy, closeness, emotional disclosure (Solomon et al., 2008), problem-focused (rather than emotion-focused) coping strategies and high levels of tangible and intangible social support from family members and military peers (King et al., 2006; Wilcox, 2010).

6.2 Research Aims

Issues surrounding military and ex-military spouses' well-being and employability have been highlighted not only in recent studies but also by organisations/charities that support them (e.g., Army Families Federation). Nevertheless, research on this group of people in the UK is limited. It is unclear how veterans' spouses/partners experience their husbands'/partners' transition as individual agents, the implications on their emotional well-being, personal, social and professional life. Most studies investigate those issues either on military spouses/partners or veterans' spouses/partners whose husbands/partners partner suffer from ill mental or physical health. It is also crucial to better understand issues surrounding family reintegration during transition, along with how the emotional and practical challenges of the transition affect the relationship and the balance between the couple. Most studies investigate these topics when military personnel return from combat or long deployments rather than when they leave the military and become civilians.

The awareness of the unique challenges faced by veterans and their families translates into better overall outcomes for this population. This study aims to explore this gap, contributing to the existing UK literature, by exploring female spouses'/partners' perceptions and lived experiences of transition in two levels:

i. *Personal level*: gaining a more sophisticated understanding on how spouses/partners experience their husbands'/partners' transition to

civilian life along with potential emotional consequences or practical difficulties.

ii. *Interpersonal level*: gaining a better understanding of the dynamics between the couple during this period, could help identifying potential factors that facilitate or impede the relationship during transition from military to civilian life.

6.3. Method

6.3.1 Study Design

This study is a qualitative study based on semi-structured, in-depth interviews with military veterans' female spouses/partners. Qualitative methods were used in order to give voice to the female spouses/partners and generate new awareness on their unique needs and the complex issues surrounding them as individuals (personal level) and as spouses/partners (interpersonal level).

6.3.2 Participants

Nine individuals took part in this study. All participants were female. Participants were female spouses or partners of British military veterans and had experienced their husbands full transition (i.e., being married while serving), or part of it (i.e., in a relationship after leaving the military) into civilian life. Eight participants were spouses/partners of the veterans' who had participated in the two previous studies. It is acknowledged that participants represented a wide range of demographic characteristics. They were aged between 25 and 55. Seven participants are married to a veteran, one

participant is cohabiting, and one participant is separated[17]. The majority of spouses'/partners' husband/partner had served in the Army and this may have led to spouses/partners whose husband/partner had served in other branches being under-presented. Table 16 outlines participants' demographic characteristics.

Table 16 Participant Demographics (Spouses/Partners)

Code Number	Age Group	Marital Status	Children	Military service	Relationship started Before/After military service	Education	Profession
P1	31 -35	Married 14 years	Yes	Army	Before	Higher National Certificate (HNC)	Part-time
P2	26 - 30	Married 6 years	No	Army	After	University educated	Not employed
P3	26 - 30	Cohabiting 9 months	No	Royal Marines	After	University educated	Full-time
P4	46 - 50	Married 22 years	No	Army	Before	University educated	Full-time
P5	20 - 25	Separated (currently) 4 years in a relationship	Yes	Army	After	University educated	Full-time
P6	41 - 45	Married 10 years	Yes	Royal Air Force	Before	University educated	Part-time
P7	51 - 55	Married 16 years	Yes	Army	After	GCSE	Part-time
P8	36 - 40	Married 9 years	Yes	Royal Navy	Before	PhD	Full-time student
P9	30 - 35	Married 10 years	Yes	Army	Before	Degree LLB	Full-time

[17] Participants who took part in this study are noted as "Ps/p".

6.3.3 Interview Protocol

Questions centred on participants' thoughts, feelings and complex needs during veterans' reintegration and readjustment to civilian life as well as the coping mechanisms employed to support themselves and the veterans. A semi-structured interview protocol was developed from these areas of interest for the interviews. A copy of the interview protocol can be found in Appendix 6.

6.3.4 Procedure

Participants were recruited using snowball sampling. The researcher informed male participants from the previous two studies (i.e., NLI and CM), who were married or in a relationship, regarding this study. If their female spouses/partners were happy to take part and share their experiences they were contacting the researcher directly. Participants live across the UK, which is why seven of the interviews were conducted via telephone, to accommodate the participants. Two participants could meet the researcher in person. The interviews were conducted in local libraries, where the researcher had booked a room in advance.

During the interviews:

The researcher communicated the interview questions ahead of time to participants, along with a general introduction about the study. For telephone interviews the researcher sent the relevant documents to the participants via an e-mail. Participants were requested to read the information sheet and the consent form, and time was allowed for the participants to ask relevant questions about the study. Issues of anonymity and confidentiality were

explained to them, as were the reasons for using a Dictaphone or ACR (a call recorder app for phone interviews) to record the interview (in order to enable a detailed transcription to be made). Participants were informed that they could withdraw from the study at any point without further consequences. Participants were requested to sign the consent form before the beginning of the interview. Their name was replaced by a code number and any names mentioned in the interview have been changed. The interviews were conducted between December 2017 and October 2018. Interviews were carried out in English and transcribed by the researcher. They varied in length from approximately 20 minutes to 35 minutes.

6.4 Data Analysis

Full transcriptions were made and the transcripts were coded to generate ideas and themes for discussion. This was done using the six-phase approach recommended by Braun and Clarke (2006) as the most efficient and rigorous way of conducting thematic analysis. This approach commenced with the researcher reading the transcripts several times to become familiar with the content. Preliminary analysis was then undertaken to code data representing specific areas of content. Codes were then carefully examined in relation to the overall research aims of each study to ensure their relevance and then identify potential themes. These themes were discussed with the supervisors and refined to ensure their relevance to the scope and intent of each study. The analysis was primarily inductive, aiming to identify key aspects of spouses'/partners' perceptions and lived experiences of transition. A semantic

approach was employed to identify themes within the explicit meaning of the data. It is important to note here that the analytic process involves a progression that goes beyond a simple description of the data, to an interpretation, attempting to present the significance of these patterns and their meanings in relation to previous literature (Patton, 2002). Quotations are verbatim, with non-verbal elements removed to improve readability. NVivo 11 software was used for data analysis (QSR International, 2016).

6.5 Prelude to Results: Veterans as Husbands/Partners

The aim of this sub-section is to present a concise summary of veterans' perceptions and subjective experiences, specifically regarding their spouses/partners, based on the data analysis in Chapter 3 (both part 1 and 2). Summarising veterans' key points of view about their spouses/partners (presented in chapter 3) and how spouses/partners experience the transition (presented in chapter 6), will help to explore and better understand the dynamics between the couple during transition and the factors that may facilitate or hinder the relationship (presented in the Discussion, section 6.7). As explained before, eight out of nine female participants were spouses/partners of the veterans who took part in the two previous studies.

Overall, data analysis in chapter 3 indicated that the transition process and all the challenges that followed (depending on the unique situation of each individual) were not always handled appropriately or in a timely manner. This was due to the lack of understandable and relevant information and an overall lack of awareness about mental or physical health issues or ways to manage

specific aspects of transition (e.g., finance, employment). However, the importance of the emotional and practical support offered by spouses/partners was highlighted by the non-single veterans. In particular, empathy was identified as a key facilitator, which provided a solid foundation and helped in maintaining a healthier relationship, especially during challenging periods. Many times, veterans had to deal with worry and uncertainty, while experiencing various emotional or practical challenges, such as work-related problems or health issues. Having the support of their spouses/partners by their side, advising and guiding them was a constant encouragement and reassurance. This was an important step towards establishing honest communication, but also helped them become more comfortable to discuss their intrusive thoughts or aspirations for the future, which in turn, reduced the relationship stress[18]. Nevertheless, while discussing how important the support from their spouses/partners was, veterans acknowledged that transition from military to civilian life, was not only challenging for them as individuals, but also for their spouses/partners and the relationship itself. Veterans held themselves accountable for many of the problems that occurred in the relationship, due to their own inability to actively cope with health problems, control their emotions or undertake responsibilities in civilian life. Miscommunication between the couple was

[18] For further details please see: Ch.3, theme 3.2.2.4 – i "*Feeling grateful*", page 157.

identified as a key barrier; it negatively affected veterans' mental health and hindered their efforts to re-shape an identity as individuals and at the same time re-establish their role as a husband/partner[19]. To conclude, veterans were trying to balance their emotions between feeling grateful for everything their significant other did (and still does) for them and guilty for all the additional strain and all the trouble they have put them through, due to their own inability to take responsibility for their actions. Nevertheless, it was acknowledged by all veterans who were married/in a relationship, that (despite the challenges) spouses/partners were significant figures in their lives and their support buffered against all the negative effects of stress during their transition to civilian life.

6.6 Results: Spouses/Partners of Veterans

From the analysis of the transcripts of veterans' spouses/partners, two main themes emerged, described by several sub-themes (Table 17). The first theme '*Struggling to Adapt*' outlines the challenges spouses/partners face during transition, focusing on their thoughts, feelings and the impact on them as individuals and as one half of the relationship. The second theme '*Adapting to Struggle'* outlines the factors that facilitated spouses/partners to learn how to

[19] For further details please see: Ch.3, theme 3.2.2.3 – ii "*Lack of understanding*", page 155 & theme 3.3.2.3 – iv "*Feeling alone*", page 189.

maintain the balance between theirs and their husband's/partner's needs, while building a healthier relationship.

Table 17 Themes Chapter 6

Themes	Sub-themes
Struggling to Adapt	*(i) The new reality* *(ii) Nothing was set* *(iii) Inability to maintain a balance* *(iv) Loss of connection with self*
Adapting to Struggle	*(i) Self-reflection & realisation* *(ii) Efforts towards re-connection* *(iii) Re-building a more stable environment*

6.6.1 Struggling to Adapt

(i) The new reality

Transition to civilian life was for many a complex process, which added additional strain to the individuals (as separate agents) and the couple (as a whole) and as explained by participants, it took a long time to get out of this situational despair. Veterans' mental health problems, physical injuries and alcohol misuse per se, along with any consequences involved, were considered major issues as they magnified the tensions between the couple. The new reality represented the unknown and was described as a vicious circle of stress that increased the unresolved issues between the couple and many times led to aggressive or even abusive behaviours towards spouses/partners.

Ps/p5: *"I felt there was a lot of pressure on me. And I went through every*

struggle of ours alone because he had in his mind that he always worked hard and I felt like he never thought about the things that I did […] he had gone out and he got very, very drunk. We had an argument and it got violent. And it was from that point I was like I can't do this anymore…"

Ps/p9: *"There have been times when he's turned heavily to drink. That has caused big issues, big, big rifts between the whole family, not just us as a couple… It all reflects back to the Army […] I think it's been used as a sort of escape from the way that he's feeling. Then behaviour changes, and that's when… That's not been good throughout the last few years…"*

In many cases, it was difficult to understand what their husband/partner was suffering from or the consequences of it and to effectively accommodate and support him. This in turn led to many long-term problems in the relationship.

(ii) Nothing was set

In these complex situations, participants argued that any type of support was crucial. Yet many of them experienced lack of support and considered it a major barrier in their efforts to bridge the gap between them and their husband/partner. More specifically, lack of emotional support from family and friends made transition period unmanageable, putting, sometimes an insurmountable, strain on spouses/partners (and in turn on the relationship), as they had to manage all the challenges by themselves. The more severe veterans' mental or physical health status was, the harder it was for participants to accommodate their needs alone, while coordinating daily and family responsibilities (e.g., being pregnant or taking care of the children).

Ps/p1: *"…I was an hour away from family and friends. Even getting him to go see the doctor. That was up to me with his wheelchair, to go and take him to the army… and I was pregnant. Trying to get him into the car and his wheelchair as well, it was mentally and physically a struggle […] when I had the baby, I needed help with childcare when my mom went to work. I had to look after him* [husband] *and I asked his mom. She didn't really like it. She hadn't dealt with someone with a brain injury before".*

The practical support and guidance from external sources, such as the military, NHS or relevant services and armed forces charities, was considered equally important and the lack of it also led to a number of latent problems, which in turn impeded the quality of the relationship.

Ps/p7: "*The minute my husband retired, that was it, no communication, even silly things like you kicked off the Facebook pages… so you don't know what's happening and…We've got no support […] it's like you're a big part of their family but the minute you're not you're cut dead, which I don't think it's good for dependents and everything else".*

What was highlighted by all participants as a consequence of the lack of practical support, was the lack of knowledge regarding the nature of issues surrounding transition and re-adjustment to civilian life, including mental and physical health. The importance of raising awareness of the complex issues that may occur during transition, as well as offering targeted information about the nature of mental and physical problems, would have been a key facilitator

not only for spouses/partners, but any other individual (e.g., other family members or friends) who is part of veterans' lives and support network.

Ps/p2: "*I think it's important that somebody you know, civilians realise what we deal with and you know what they* [veterans] *go through, and that's very important. I think that there definitely needs to be some changes, the system doesn't work… I think that the problem is underestimated, how bad this PTSD and other conditions through the military are… and I think that something needs to be done way deeper…"*

Ps/p8: *"…maybe if they had like kind of you know more information for partners' as well. I don't think I was prepared for how much he would struggle with this and how different it would be".*

What was reported by several participants was the need for more official and organised support and guidance; for example, information on potential reintegration challenges and ways to effectively manage emotional distress or everyday challenges to facilitate veterans' transition and maintain a healthy relationship in the long-term.

(iii) Inability to maintain a balance

Participants identified the limited choices and the lack of control over their lives they felt they had, as major consequences to the changes and challenges that followed their partners' transition to civilian life. Regardless of veterans' needs and the dynamics in the relationship, participants felt that they had to make all the compromises and carry the burden of saving the relationship alone. Even though for some the experience was more intense than others, all

participants stated that they had to devote their personal time and make many sacrifices to meet their husband/partner on their level until they were back on their feet.

Ps/p8: *"…my kind of patience for things only kind of goes so far… I definitely struggled just for having him right all the time […] he wasn't working cause of his brain injury, so just at home on the couch, so that was doing my head in… it was a real pain… and I think it did put a lot of stress and strain on…"*

The most common issues reported during this challenging period, were the various and complex responsibilities to act as carers, relocate despite the personal consequences involved, sacrifice their career by leaving their job or working less hours, lose touch with friends and stop things that offered them personal satisfaction, such as hobbies. At times it was difficult for participants to accept these major life changes in their lives and they had the tendency to affix blame to their husband/partner.

Ps/p1: "*When we got chucked out of the army, when he got medically discharged. We had to apply back for housing. And I tried carrying on with my work but it was taking an hour and half to travel. Our daughter was one at that time and I really didn't want to be doing that. Even doing part time, an hour was really a trouble […] I did feel alone, I did feel we were completely on our own*".

Ps/p4: *"I blamed him* [husband] *for the fact that I had given up. I had given up a job that I loved, I had given up a house that I loved to move down to a place*

that I hated. Umm, and we just couldn't work out and I just decided to leave, take the children and leave. Which was, umm, very difficult".

Practical and emotional inequalities in the relationship were reported by participants and the struggle to maintain the balance between their personal and their husband's/partner's needs was highlighted. Many of them argued that they were performing a disproportionate amount of responsibilities. They felt unappreciated at times as their efforts were not always recognised by veterans, usually due to latter's emotional distress and inability to cope with their own personal transition to civilian life. For example, participants who were pregnant or had children explained that things became even more complicated, especially during the first period of veterans' transition, when they had to carry the heavy burden of being not only spouses/partners, but also a carer and a parent.

Ps/p5: *"In his head, I wasn't doing anything while he was doing everything. And that was kind of tough on me because I always felt like I never wanted to put it on your face when you didn't have a job at all. And you're having your lone time and I'm just here because I've got me being on a break to have our child and it was constantly rubbed on my face. So that was quite a struggle for us as well…"*

In combination with the above, lack of interpersonal communication was negatively affected the relationship.

Ps/p1: *"…it was the communication. I would kind of visit and he wasn't talking to me at all. We would ignore each other when I was sitting there with him […] I sat there really excited to see him and he just sat there, full time completely*

ignoring me. As soon as I went, I just looked back and he started talking to someone right next to him about the football. So, it's just the communication. He just didn't really engage in any conversation and he didn't open up about his feelings".

It was explained by participants that despite their efforts to effectively communicate and re-connect as a couple, not being able to share their fears, feelings and thoughts, often led to constant arguments and worsening of their relationship in the long-term.

(iv) Loss of connection with self

Participants described a loss of connection with their own identity as a consequence of having to adjust into the new reality. What was highlighted the most was the challenge to maintain the balance in the relationship, which always resulted in putting themselves, their needs and any opportunities for self-development second. The 'emotional labour' was eroding the relationship, with participants feeling that they were the only ones who initiated, delegated and worried about everything while losing themselves in the process. They reported significant emotional distress, involving relatively passive feelings of loneliness, sadness and frustration, due to the lack of control and choices over their lives and the inequality in the relationship as experienced by them.

Ps/p5: "…*instead of kind of helping it, I kind of put myself back a bit and I didn't really think about myself anymore. I didn't really know I had done that until we had broken up, then I thought actually I can just think about me now. I just never really did anything to help myself because I just put everything into*

helping him because I thought that if I could really help him and he was happier, then I could finally help myself".

Ps/p9: *"When he doesn't want to talk, I feel he's shutting me off. Then I can sometimes get on the defensive and feel hurt by that…"*

The lack of opportunities for emotional containment along with limited emotional or practical support, increased emotional distress and feelings of loneliness. The psychological and physical impact on behaviours, energy levels and overall well-being were also reported by participants as a result of all the practical and emotional challenges during transition.

Ps/p4: *"I did start taking anti-depressants at that time because I had been very low particularly after I had the baby and then moved so quickly […] he worked very long hours when we were at [name of the place] and I got pregnant again. And I think that time is probably when it just became really awful. I was drinking too much trying to comfort…"*

Participants' inability to maintain a sense of identity while the relationship was falling apart, led to the development of unhealthy behaviours, such as substance misuse, in order to cope with the relationship strain.

6.6.2 Adapting to Struggle

(i) Self-Reflection & realisation

Several participants were familiar with the military culture, either because an immediate family member had served in the military (e.g. father) or they were already married/in a relationship while their husband/partner was serving.

Participants acknowledged that past life experiences, background and general knowledge regarding the military culture, played a significant role in finding more effective ways to cope with the challenges in their relationship that occurred during the transition period. They explained that this past knowledge allowed them to be more flexible in the way they were managing practical difficulties or veterans' behavioural problems.

Ps/p3: "*I'm from a military family myself, my entire family is in the military […] I would be stressful for him* [boyfriend] *in a sense it wasn't pleasant for anyone to have a nightmare. And I think this is not like that prone because all my life I've been involved. I have seen these things with my dad. For me it kind of comes in the territory so I would say personally, I've stuck before it".*

Similarly, participants who grew up in dysfunctional family environments also reported that they were familiar with volatile or aggressive behaviours and thus more mentally prepared to manage them and cope accordingly. Due to their past experiences, participants were able to better understand and tolerate veterans' complex behaviours. Demonstrating higher levels of patience towards veterans' unhealthy attitudes, helped participants to become more resilient.

Ps/p5: *"It was quite natural for me because I've grown up in a quite hostile environment and my dad is bipolar, so I know how to handle different mood swings and stuff. So, I found it a lot easier and I think that I why he came to me more than his own family, 'cause he knew I was a lot more accepting".*

Overall, participants acknowledged the importance of being able to constantly adjust to the new reality. This was an opportunity for them to reflect and focus more on their own strengths and weaknesses, while becoming stronger and more determined.

Ps/p7: "*I'm quite a strong person. I can deal with things myself. I'm more than capable of- I can throw everything out. You're just aware that there is no backup* [the military]. *It's not that I've needed anybody, but before that you knew there was always somebody there. Whereas now there's nobody"*.

However, despite participants' efforts to follow a more dynamic approach to help their husband/partner and achieve a healthier relationship, it was highlighted that the uncertainty, the emotional instability and the various relationship problems need patience, time and continuous efforts from both partners.

(ii) Efforts towards re-connection

Participants came to the realisation that by showing empathy and being able to accept particular behaviours, alleviated difficult situations many times. Recognising the signs of emotional distress and act accordingly, for example give time and space to their husband/partner to cope with it by himself, was proved to be a solution to many issues and in the long-term decreased the arguments or misunderstandings between the couple.

Ps/p2: "*I think at that time I was putting myself into work leaving him to deal with it himself, being in safe distance if he needed me, but, leaving him, I didn't know what to do so…"*

As mentioned in previous sub-themes, the lack of targeted knowledge, support and guidance during this challenging period was described as a key barrier, which increased feelings of helplessness. That is why any type of emotional and practical support from family and friends was valued so much by participants. Support was an opportunity for them to maintain a strong support network, share their experiences, feelings and thoughts and reduce the feelings of isolation or helplessness.

Ps/p5: *"I've got 2 best friends… So, I have them to ring every now and then and I'd speak to them about my problems […] she* [friend] *was someone really good to be able to talk to because she knew how bad it could get. So, she was really good to have, I don't know how much harder it would have been if I didn't have her to talk to".*

At the same time, achieving and maintaining an honest interpersonal communication was recognised as a key facilitator, which helped participants effectively manage challenges. Accepting all the issues that occurred during transition (e.g., mental health problems, physical injuries, practical challenges, financial hardship), allowed participants to understand their husband/partner on a deeper, more personal level and strengthen the bond of their relationship.

Ps/p3: *"It's nothing about easy, I'd say I feel that its fine, but it has its challenges. There're times where he's just doesn't know, he has very much going on in his mind* […] *We kind of just know, we talk a lot. We do communicate a lot so that's a massive thing. So, if he's struggling, we adjust things accordingly".*

On its own, the effort of establishing an honest communication evolved and became a constructive coping strategy, which facilitated not only them as individuals but also strengthen the dynamics in the relationship. This created a healthier environment, where the couple felt safer and able to relieve feelings of stress and reduce the feelings of loneliness.

(iii) Re-building a more stable environment

The realisation of the key factors, which facilitated all these difficult situations, did not mean that problems were automatically resolved or that spouses/partners were always able to effectively manage challenges and successfully support their husband/partner. However, participants argued that their determination to overcome any issues and save their relationship, helped them to remain realistic and enhanced their resilience towards the numerous challenges during transition.

Ps/p2: *"…when he relapsed, I certainly then had to give up my job. Um, didn't really socialize with friends and stuff because I couldn't risk leaving him in the house […] I didn't mind doing that because you do that when you love somebody…"*

Ps/p7: "*We're more organised. We don't see him as much* [husband works abroad] *but we know exactly when we are going to see him. We can then book holidays and we can go our life around his work, whereas before we couldn't* [while serving]. *You had no control whatsoever. Whereas, at least we've got a little bit more control now. He earns a lot more money now he's not in the forces, even though he's doing the same job.*

All participants, apart from one, are still married/in a relationship yet even this individual explains that despite the continuous challenges and their mutual decision to break up, she still cares about and supports her ex-partner and together they try to maintain a healthy environment for their child.

Ps/p5: *"now I've put myself first again and since we've broken up I felt like I've got more freedom doing what I want […] the one thing that I do wanna make sure is that everything is okay and that we all set along and going well for [child's name] and that he doesn't have to grow up in a bad situation. We've agreed on that and we're both very happy for that. Although we're not a family together, we're still his family…"*

Despite all the personal sacrifices, the challenges and the unique situations each participant experienced, they all tried to focus on how to set new relationship goals and remain optimistic. The love and affection towards their husband/partner gave them strength to continue and helped them maintain a sense of self and control. This led to decreased stress levels and a stronger, healthier and more truthful relationship.

Ps/p3: "*I think one of the biggest things he's said to me is that, you know, for him, I'm the person he shares the most with, about his time and about what process he thinks occurs and that has helped him in huge amounts so I say that's that biggest thing of all*".

Overall, participants may still face difficulties and still working hard on maintaining the balance in their marriage/relationship yet through the process

of supporting their husband/partner in their transition to civilian life they also better understood themselves and learn how to grow through challenges.

6.7 Discussion

This study attempts to (i) explore veteran female spouses'/partners' lived experiences and perceptions of transition to obtain a more sophisticated understanding of the emotional and practical implications of this complex life change but also (ii) gain a better understanding of the dynamics between the couple during this period. Both of these will help identify potential factors that facilitate or impede the relationship during transition from military to civilian life.

Transition to civilian life represents a new beginning not only for veterans but also their spouses/partners. Upon reintegration, both parties have to deal with different types of adjustment as each person is likely to create different meanings and narratives about the experiences of reintegration (Bowling & Sherman, 2008). For many this was a complex, challenging period, different from their normal routine to date, when they were struggling to adjust and did not know how best to navigate civilian life. Spouses/partners became more sensitive to socio-environmental factors or external contingencies. In particular, they became more vulnerable not only to relationship stressors liable to affect their well-being, but also to the associated internal contingencies, such as their self-worth and self-esteem. Increased stress, feelings of isolation and loneliness or direct conflict were reported as a result of the emotional distance between the couple. In line with other studies

(Mansfield et al., 2014; Murphy et al., 2017) current results suggest that spouses/partners who had to act as carers due to veterans' ill physical or mental health, reported additional challenges, including inability to maintain a sense of self, lack of independence, control and autonomy (Dekel et al., 2005). Alcohol was acknowledged by both parties as a key barrier, which impeded the relationship and raised practical and emotional barriers between the couple. Alcohol misuse is often associated with a range of common mental health disorders and linked to antisocial behaviour. Indeed, rates of alcohol misuse in the UK military and ex-military population are higher than the civilian population (Murphy & Turgoose, 2018). Even though there is an extended body of literature investigating harmful alcohol and drug consumption among the military and ex-military population (e.g., Jones & Fear, 2011; Teeters et al., 2017), the implications of substance misuse on the marriage/intimate relationships among this population has not been investigated thoroughly. Numerous sacrifices were reported at personal and professional levels by spouses/partners including, relocation, low job satisfaction and no personal or social time as a result of focusing all their attention and energy in supporting their husband/partner to successfully manage their transition. This appeared to have complex implications on their sense of self and well-being and in turn reduced the quality of the relationship. All these were also acknowledged by veterans, who many times emphasised their feelings of regret and guilt for the practical and emotional problems they caused to their spouses/partners. The stability and functioning of the relationship were affected by these personal and interpersonal challenges, causing disruption and additional strain between

the couple (Norris et al., 2018). Avoidance, emotional numbing, lack of communication and sharing of feelings were reported as major issues from both parties regardless of veterans' health status (i.e., healthy versus ill physical/mental health). Indeed, open and honest discussion can be challenging for veterans who tend to isolate and withdraw (Sherman, Zanotti, & Jones, 2005). In such cases, maladaptive coping strategies were employed by spouses/partners, such as avoiding conflict by supressing their own emotions or in some cases substance misuse (e.g., alcohol or antidepressants). Such coping mechanisms may be harmful for health and well-being in the long-term, yet despite wide-spread alcohol misuse among military personnel, there is limited evidence concerning alcohol misuse among military (Gribble et al., 2018) and veteran spouses/partners.

An important finding was that spouses'/partners' background and life experiences facilitated the way practical and emotional challenges were managed. Previous direct experience with or knowledge of the military culture (e.g., from parents), or growing up in dysfunctional family environments, increased their understanding of and empathy for veterans' complex behaviours and attitudes. This was also highlighted by veterans themselves as a factor that helped their marriage/relationship (while serving and during transition). Similar studies (Bergmann et al., 2014; Erbes et al., 2011) suggest that demonstrating patience and tolerance towards vulnerable veterans may increase spouses'/partners' resilience and inner strength. Despite having to consume physical and emotional resources, spouses/partners demonstrated high moral commitment towards their husbands/partners, which in cases

restored the balance in the relationship. It was emphasised many times by veterans that their spouses'/partners' high levels of empathy and the sense of feeling understood was crucial in maintaining a balance in the relationships while trying to tackle their own personal problems and the problems that occurred in the relationship. Indeed, releasing suppressed emotions was acknowledged by both veterans and their spouses/partners as an important step in the development of intimacy, trust and emotional attachment (Stafford & Grady, 2003).

Availability or lack of support was crucial for both parties. The protective nature of emotional and practical support offered, either by family members or professionals, buffered against psychological distress. For spouses/partners the opportunity to share their experiences and emotions with people they can trust, provided reassurance and confidence that they would be understood. On the contrary, lack of support in combination with lack of knowledge and information regarding either the challenges surrounding their husbands'/partners' transition to civilian life or specific guidance on how to accommodate and support those with ill mental or physical health, was associated with poor relationship outcomes and increased the psychological distress and burden among the couple.

Limitations, Future Research & Implications

The small sample size, the variation in marital status (and having children or not), length and the time frame of the relationship (before or after military service), lack of representation of Royal Navy and Royal Air Force means

caution should be taken when considering these findings in terms of the wider veteran spouse/partner population. The majority of the qualitative data was collected via telephone interviews, and while there is criticism, this method can provide social and physical distance from the interviewer, allowing participants to feel more comfortable discussing sensitive issues (Mealer & Jones, 2014). While other studies isolate issues faced by military or veteran spouses/partners (e.g., impact of deployments or supporting veterans with PTSD), the cross-sectional nature of this study allows for a more sophisticated understanding of the common challenges among this population, shedding some light on under-researched themes. In order to develop a more holistic understanding of this population and in turn improve healthcare services, future research should explore the implications of military transition between female veterans' and male spouses/partners, as well as among homosexual or transgender ex-military personnel. In addition, comparisons with other populations, such as couples of emergency responders or the general population could shed light on the unique challenges couples of the ex-military population face.

Military personnel come under numerous pressures throughout their military career that can have direct and indirect negative impact on them but also their families. Military spouses play a key role in buffering all the negative effects of transition (e.g., emotional distress, ill physical and mental health) and enabling veterans to reintegrate into civilian life and workforce (CSJ/FiMT, 2016). The study indicates the need for continuous improvements and additional support from health care services (e.g., NHS, armed forces charities), to reduce

practical and logistical barriers in seeking help. Psychoeducation, raising awareness, sharing information and offering targeted guidance are necessary for spouses/partners in successfully navigating life after transition and effectively accommodating veterans with ill mental or physical health.

6.8 Conclusions

This study has begun to describe the unique and complex experiences female spouses/partners of veterans may face during their transition from military to civilian life (i) in a personal level, but also (ii) in an interpersonal level by exploring the dynamics between the couple. Numerous barriers impeded the quality of the relationship revealing the multi-dimensional stressors experienced by both spouses/partners and veterans. Nevertheless, healthy communication and flexibility on managing emotional and practical challenges restored the balance in the relationship and increased the sense of empowerment in both. Results indicate that not only couples in which veterans were struggling with ill mental or physical health faced challenges, but rather all of them had to cope with some kind of problem. Further research should explore in-depth the differences and commonalities of intimate relationship problems among healthy and vulnerable veterans in heterosexual and homosexual relationships. In turn, relevant healthcare services and clinicians should improve current interventions that support spouses/partners of veterans by raising awareness, offering tailored information and guidance, addressing their unique individual needs, and ensuring that it is accessible to all.

Chapter 7: General Discussion & Conclusions

7.1 Introduction

Transition experiences vary greatly among military personnel depending on their personal experiences, yet the majority of personnel leaving the Armed Forces do well after leaving (FiMT, 2013; HoP, 2016). However, there is a significant minority of individuals, including those with poor mental or physical health, who are at higher risk of becoming unemployed or socially excluded after leaving (Johnson & Murariu, 2015; Samele, 2013). Despite the numerous studies on military and ex-military personnel, which cover all aspects of transition (e.g., employment, financial support, housing, mental and physical health issues) the continuous efforts to actively support the veteran community and facilitate the transition process, major barriers remain. In order to actively improve the transition process from military to civilian life a better understanding of the underlying barriers or potential facilitators that have not been identified, is necessary.

7.2 British Veterans' Narratives of Transition to Civilian Life

The main objective of this PhD research was to conduct in-depth research into veterans' pre- and post-military experiences and obtain a deeper insight into the problems faced by this significant minority of physically and/or psychologically traumatised veterans, who try to re-shape their identity and re-build their life in the civilian word. This in turn allowed for the development of a Holistic Model of Military Transition (HMoMT) based on empirical research in the UK. The key element of this model is that the veterans' perception of the

transition plays a significant role in understanding how they can be affected by their changing life events as much as the type, context and impact of the transition itself (Barclay, 2017; Schlossberg, 1981). The ability to cope with transition can be influenced by a set of factors (Schlossberg, 1981, 2011): the veterans' situation at the time of transition, their inner strength for coping with challenging situations, the (emotional and practical) support available at the time of transition, which was critical to their sense of well-being, and the ability to be flexible in using the appropriate strategies that will enable them to better cope with challenges and manage their transition. Transition is indeed a complex process, which despite the many common challenges and barriers faced by the veteran community, remains a unique subjective experience for each person. The main point identified by drawing on veterans' lived experiences is the constant need for motivation and purpose. Results indicated that the ability to identify a strong purpose and remain motivated in any life stage (e.g., in youth, while serving in the military, transition to civilian life) was associated with positive memories and outcomes and a strong sense of pride, despite any challenges faced during this time. On the other hand, the lack of purpose and motivation were associated with emotional distress, negative memories and outcomes and lack of pride. It is acknowledged that this is a qualitative research project and hence no claim to statistical representativeness is made, but rather it is assumed that findings can reflect valid descriptions of sufficient depth and contribute to the development of conceptualisations of the military transition as a phenomenon (Ayres et al., 2003). The main aim was to provide a rich, contextualised understanding of

veterans' subjective experiences of transition from military to civilian life, rather than argue on the attainability of generalisability through the HMoMT. However, at the same time, it is important to ensure that insights from qualitative research are recognised as important sources of evidence for practice.

Veterans' narratives of the double transition (i.e., from civilian to military and from military to civilian life) followed a cyclical pattern (Figure 3): (i) from needing a purpose in life at a young age, (ii) to finding and maintaining a strong purpose while serving in the military, (iii) to losing their purpose during or upon leaving the military and (iv) finally seeking a new purpose in civilian life

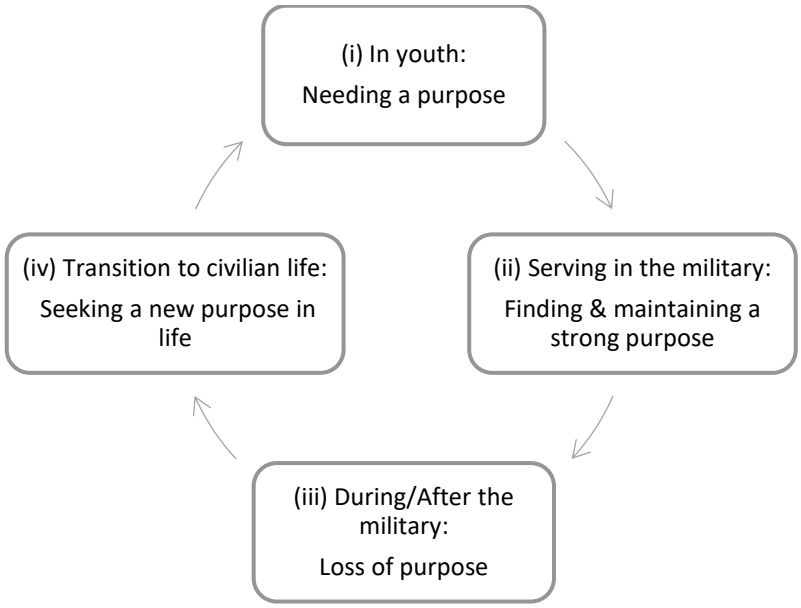


Figure 3 The cyclical pattern of transition

This cyclical pattern of 'seeking, finding, losing and re-seeking for motivation and a strong purpose in life' and the need for a stable sense of identity are inextricably linked (Figure 4). Individuals' identities are not static, they reshape in response to a variety of complex personal, social and cultural factors. Re-

organising the self-concept and integrating new identities into the sense of self can be a challenging process, especially during transitions that are on a high level of identity disruption (Amiot et al., 2007). Results suggest that the (i) transition from being a young individual who has not yet developed a sense of identity, but (ii) manages to build it by joining the military (iii) and losing it during or upon leaving the military can be a major identity disruption (iv) resulting in increased levels of low self-esteem, a loss of self-confidence, isolation, loneliness, all of which threaten individuals' ability to connect to themselves and those around them while transitioning to civilian life. Indeed, individuals who manage to successfully shape an identity can develop a coherent, integrated sense of self, while failure to do so may result in identity confusion or diffusion (Schlossberg, 2011; Schwartz, 2004).

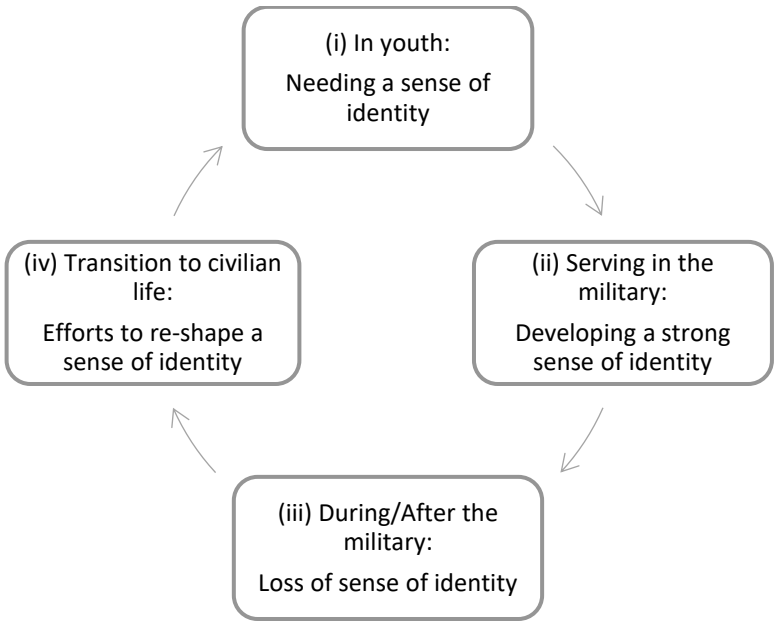


Figure 4 The cyclical pattern of the sense of identity

7.2.1 Needing a Purpose & Sense of Identity

The military remains a major institution in the lives of many young individuals in the UK and it is very common for youngsters to make the decision to join the military straight after compulsory education, rather than continuing with higher education courses, joining the civilian labour force or doing some other activity (Kleykamp, 2006; Spence, Henderson, & Elder, 2013).

Veterans who took part in the studies of this PhD represented a wide range of demographic and military characteristics. Young individuals who grew up in deprived areas, with household income poverty, lack of parental support and domestic abuse who were involved in anti-social or risky behaviours. Maladaptive coping strategies, such as alcohol and drug misuse, school dropouts or illegal activities, were common among disadvantaged youth. On the contrary, young individuals who grew up in families with high socioeconomic status, with caring parents and higher levels of belongingness within their schools and communities, were generally associated with positive childhood experiences, higher academic achievements, future aspirations and decreased risk-taking behaviours. Constructive coping strategies, such as goal setting, problem solving, help-seeking behaviours or participation in extracurricular activities, were common among high socioeconomic status adolescents. Results tie well with previous studies, which investigate the impact of socioeconomic background, family characteristics and school climate on adolescents' well-being and engagement in constructive or maladaptive coping strategies (Alexander, Entwisle, & Olson, 2014; Berkowitz, Moore, Astor, & Benbenishty, 2017; Escarce, 2003; Harvey & Delfabbro, 2004; Lim,

Gemici, & Karmel, 2014; Magson, Craven, Munns, & Yeung, 2016; Morris, Manley, & Van Ham, 2018; Serbin et al., 2011; Visser, 2003). Indeed, the main settings, which can influence the way children and adolescents grow up include family characteristics, neighbourhoods, and schools. The quality of these settings, and whether they are supportive or destructive, has a profound influence on young individuals' chances for leading successful adult lives (Escarce, 2003).

Research on military enlistment decisions indicates that young individuals join the military for a variety of psychological and/or economic reasons (Bachman et al., 2000; Eighmey, 2006; Gibson, Griepentrog, & Marsh, 2007; Ginexi, Miller, & Tarver, 1994; Kilburn & Klerman, 1999; Lawrence & Legree, 1996; Spence et al., 2013; Woodruff et al., 2006). Current results also suggest that both subjective beliefs (e.g., positive perceptions of military) and practical life circumstances (i.e., socioeconomic background/life experiences) can have a great impact on the enlistment decisions. The main common motivators associated with subjective beliefs were the need to find a sense of purpose and belonging, along with opportunities for personal growth and self-improvement. The main common motivators associated with practical life circumstances were job security in combination with adventure/travelling, and future goals, including building a career and education opportunities (e.g., professional qualifications/trades).

Young individuals who had a challenging life, decided to choose a different path in life after acknowledging that risky behaviours or associations with

unhealthy family environments would ruin their future. Enlisting in the military was considered an 'escape plan' and an opportunity to respite from aversive circumstances, such as unemployment, low educational attainment and risky behaviours, such as drugs/alcohol misuse or illegal activities. Military recruitment often promotes the military as a family orientated environment, which provides individuals with an increased sense of belonging (Spence et al, 2013). Indeed, young individuals (especially those from disadvantaged backgrounds) believed that the military life could fulfil their desire to belong somewhere, be part of supportive environment, achieve a better future and gain their independence. Overall, research on enlistment motivation patterns usually suggests that enlistment rates are lower among individuals with educated parents, high grades, or university attendance (Bachman et al., 2000; Eighmey, 2006; Kleykamp, 2006; Lawrence & Legree, 1996; Lutz, 2008; Pliske, Elig, & Johnson, 1986). Nevertheless, that does not exclude young individuals who had good socio-economic background and educational opportunities, from wanting to enlist in the military. In line with findings from similar studies (Bachman et al., 2000; Lievens, 2007; Lievens et al., 2005), the current results also suggest that young individuals who had a good upbringing and no particular troubles in school, decided to join the military either due to their positive perceptions of the military (e.g., be part of something exciting) or their familiarity with the armed forces (e.g., a family member served in the military).

This research adds to the existing literature by identifying factors which equally affected young individuals' enlistment decisions from both low and high

socioeconomic status groups. Lack of educational goals was found even among young individuals who attended university. Both well-educated and less-educated young individuals demonstrated low educational aspirations, a desire for self-improvement and a need to live an exciting life. Well-educated individuals' overall life satisfaction levels were good, but there was a reported dissatisfaction regarding their work, which included traditional 09:00 to 17:00 office jobs. On the contrary, the need to live an active lifestyle, which includes physical activities, sport, travelling and adventure positively affected enlistment decisions for both groups. It must be also noted that experiences in similar environments to military (e.g., joining sport teams, boy scouts, the cadets) helped young individuals to attain crucial and transferable skills and raise aspirations and motivation to join the military.

7.2.2 Finding Purpose & Developing a Strong Sense of Identity

Military service was considered a life-changing experience. Current findings are broadly consistent with previous military research (Elder, Gimbel, & Ivie, 2009; Gade, 2009), suggesting that overall military service is perceived as a life-course turning point and it can be significantly influenced by many factors. For example, entry at a relatively young age, the negative experiences the individual may have while serving (e.g., be exposed to traumatic events) or the positive ones (e.g., a successful military career). The transition from civilian to military life is an important turning point in a person's life, associated with significant life outcomes. It was reported that military service supported individuals to socialise and mature and it represented a path from youth to

adulthood. As part of individuals' new 'military identity', strong sense of duty and pride was developed and deeply embedded in individuals' conscience while serving.

Exploring the aftermath of military service and the transition from military to civilian life, serving in the military was considered both an 'occupation' and a 'vocation'. Military service (as an experience per se) was viewed as a strong career choice, compared to alternatives in higher education or the civilian sector, as it combined many benefits. The most mentioned ones were job and financial stability but also travelling and opportunities that would not be possible in the civilian world. It was also highlighted that, despite the challenges, serving in the military was a successful shift to adulthood, which also led to numerous positive outcomes, such as personal and emotional growth and development of strong values. Combat experience, per se, was highly regarded as crucial part of the job, regardless of the high risks involved or the long-term consequences in mental or physical health.

7.2.3 Loss of Purpose & Sense of Identity

Apart from potential rewards, such as unique experiences and skills that young individuals gained while serving, there were also substantial risks which included combat exposure, witnessing death, experiencing violence or suffering physical injuries. Current results suggest that these impactful events have had a significant negative effect on individuals' well-being, leading to both short- and long-term changes in mental health. However, individuals react and cope with traumatic events, such as witnessing fatal accident or

experiencing violence during military deployments, differently according to their subjective experiences (Jackson et al., 2012; Jennings, Melvin, & Belew, 2017; Kleber, Brom, & Defares, 1992). It is well-outlined in the literature that military experiences, such as deployment and exposure to combat are associated with increased risk of mental health problems, such as PTSD, major depression, substance abuse, impairment in social functioning and in the ability to work (Hoge et al., 2004; Kang et al., 2003; Prigerson et al., 2002; Rona et al., 2007). Common mental health disorders were also frequently identified among military personnel with physical injuries or impairments (Baker et al., 2009; Mcfarlane, 2005; Stevelink et al., 2015). Current findings indicate that during hospitalisation after suffering a physical injury, various feelings and emotions may arise, such as denial, confusion, or agitation. Other studies also suggest that physical injuries, especially the loss of body parts, can have distinct but also overlapping psychological consequences (Blanchard et al., 1995; Mcfarlane, 2005; Schreiber & Galai-Gat, 1993). Anger may occur at the same time as denial, especially for individuals who suffered severe injuries or amputations, which require long amounts of downtime. In this study, bullying was identified as a significant factor, which hindered individuals' psychological well-being, job satisfaction and motivation. Genuine bullying and robust military training can be easily confused and thus, neither are dealt with properly. Despite some studies on sexual harassment and assault (Cunradi et al., 2005; Magerøy et al., 2009; Monteith et al., 2016), bullying is also a risk factor for self-harm or suicide among military personnel, yet, it has been largely overlooked in military research (Hourani et al., 2005).

Resentment and dissatisfaction regarding the military as an organisation was reported from all participants, and not only veterans who were medically discharged due to physical injuries/mental health problems. Veterans who were retired or it was their choice to leave, also made complaints regarding the sudden change of 'attitude' of the military (as an organisation) towards them and their families. What was mostly reported was the lack of communication and interest after the end of service. It is highlighted in the results that this felt like negligence, dishonesty, lack of recognition for all the sacrifices made during service and sometimes even betrayal, especially from those who developed severe mental health or physical problems due to wrong diagnosis.

Barriers increasing the sense of loss

This study suggests that perceptions of treatment while still in the military were mixed and sometimes controversial. Overall, findings indicate that service personnel who suffered severe physical injuries were satisfied with the first-line care delivered at the unit level as well as the interface between first-line care and military treatment facilities. On the contrary, dissatisfaction and negligence were reported among the ones who suffered minor injuries, as these resulted in permanent or more serious physical problems and cost them their career in the military. Physical trauma is visible, as opposed to psychological trauma (either as a result of a physical or moral injury or combat exposure) and cannot always be identified by the individual or the people around them (Lobban, 2014; RAND, 2008). Findings suggest that military personnel either did not recognise, ignored, or avoided processing emotional

distress when it occurred, especially when it did not involve physical injuries. This acted as an invisible barrier, which hindered individuals' well-being and productivity. These findings are consistent with the literature, indicating the latent negative impact of traumatic experiences can have on mental health and productivity of serving personnel (Milliken et al., 2007; Rona et al., 2007; Sundin et al., 2014).

The lack of appropriate guidance and support regarding issues of mental health for both physically and mentally traumatised service personnel was common among the findings. What was identified to be the main barrier was the pressure to report sensitive issues, such as emotional distress, to higher ranks and not to a professional who works independently. Similarly, victims of bullying who tried to report abusive behaviours or bullying among their unit, found that their seniors wanted them to go through the chain of command, which proved to be a frustrating and sometimes very ineffective method. Indeed, the psychological welfare of military personnel is primarily a chain of command responsibility and when necessary it is aided by medical advice or other activities (e.g., third location decompression, stress briefings, Trauma Risk Management approaches) (Gilberd, 2017; Hunt et al., 2014; Keller et al., 2015; Mazur, 2005). These key factors are also acknowledged by Castro's military transition model (Castro et al., 2014) as key factors that can facilitate or hinder the ways transition is managed and have an impact on the individual progression from service member to civilian.

Despite Military's efforts to encourage help seeking behaviours or normalise mental health treatment among all military ranks (Defence Committee, 2018;

FiMT, 2013; MoD, 2018) significant barriers remain. The study indicates that the strong leadership structure of the military created a vicious circle and stopped servicemen from seeking help because of the stigma around mental health problems and the fear of being considered weak and in turn damaging their career. These findings are broadly consistent with the literature, which shows that the masculine culture of the military and emphasis on leadership, strength and toughness can be a major barrier to care and inhibit help-seeking behaviours (Britt et al., 2012; Coleman et al., 2017; Fear et al., 2010; Iversen et al., 2010; Reit, 2017; Sharp et al., 2015). It is important to note here that a part of service personnel, particularly the ones who suffered physical injuries, would have actively sought help, but either appropriate support was not available, or they did not know from whom to request it. This study identifies personnel's limited awareness of mental health issues and available services as a latent, yet major barrier to care. Unawareness defeats the purpose of having programmes which are implemented to improve mental health care provision if military personnel are not aware of them or do not fully understand their potential benefits. An important point to raise here is that even the ones who disclosed their mental health problems were not satisfied with the way their problem was handled. The main reason of dissatisfaction reported was that apart from an official diagnosis, neither appropriate information to understand the nature of their problem nor guidance on how to cope with it was offered. This study highlights the lack of a 'holistic' rehabilitation programme, which will include not only treatment for physical injuries, but also

raise awareness and educate military personnel on how to recognise and cope with emotional distress or mental health problems.

Mental health stigma is well documented in the literature as a major barrier to care (Held & Owens, 2013; Iversen et al., 2011; Kiernan et al., 2016; Kulesza et al., 2015; Langston et al., 2010; Murphy et al., 2015; Sharp et al., 2015). This study also points to stigma as a major barrier, greater than reported logistical or practical barriers, and highlights the need to re-evaluate the factors that may increase stigma; for example, individuals in higher ranks, who may continue to hold negative beliefs about mental health and do not facilitate resolution. In order for military personnel to disclose and address such sensitive issues, they have to discuss it with someone in a higher rank. A key question here is that since this person is not a trained clinician, thus their knowledge will be limited, how can they successfully support the ones in need? Ultimately this can add additional strain to the individual and destroy the balance among their colleagues. Another way to report problems is to go through bureaucracy, which is a draining process. To conclude, despite all the continuous efforts for improvements, maybe the system itself creates the problems, with internal factors hindering the process and maintaining the mental health stigma. The continuous efforts to reduce stigma in the UK military are recognised and appreciated, yet the question why the strategies for detection and treatment are not always effective, remains.

The military offers personnel varying degrees of resettlement support, such as the Transition Individual Planning & Personal Development (IPPD) or Career Transition Partnership (CTP), depending on the individual's length of service

(KCMG, 2014; Lord Ashcroft, 2012; The British Army). Current findings indicate a dissatisfaction in the way the military (as an organisation) handles the resettlement period and prepares personnel for their transition to civilian life. What was found to be the predominant reasons were (i) the inconsistency of the military in allowing serving personnel to use the whole appropriate time to prepare themselves for transitioning due to deployments or other tasks, (ii) young personnel's lack of awareness regarding the resettlement training courses or inability to select the appropriate ones, (iii) inability to attend specialised training courses which would benefit individuals' professional development, due to financial restrictions, (iv) the lack of tailored courses, which can cover the specific needs of military personnel by taking into account their age, education, skills, financial status, housing ability and employability. Broadly, some of these points have been identified in previous studies and official reports (Arkenford & FiMT, 2017; FiMT, 2013). The issue still remains, as most of the research is focusing on the problems military personnel face after leaving the military and not on effectively evaluating the existing resettlement programmes that prepare them for the transition (CTP, 2019; FiMT Report, 2014; GOV.UK, 2015).

7.2.4 Seeking Purpose & Efforts to Re-shape a sense of Identity

Barriers hindering the transition to civilian life

It is well-documented in the literature that transition from military to civilian life is a complex phenomenon itself, which leads to major changes in individuals' lives (Arkenford & FiMT, 2017; Ashcroft, 2014; Copeland et al.,

2011; Cox et al., 2018; Docherty-Hughes et al., 2019; FiMT, 2013; The British Army, 2019). According to Castro's third segment of military transition model, there are specific outcomes through which the transition to civilian life can be assessed (Castro et al., 2014). These outcomes are measured through the categories of family, work, health, general well-being and community, and are interconnected as they impact one another. These were also acknowledged as key interconnected categories that can aid veterans' transition and purpose seeking, but can also become an underlying barrier, which can hinder the process and have important implications.

This study identifies the extreme gap between military and civilian daily routine and culture as a major challenge. Veterans were unable to re-establish or even re-evaluate their role in their family, as a spouse/partner, parent, or friend and re-adjust to the family's daily activities. This led to numerous negative implications in the relationships with their spouses, partners, children, close family and friends. These daily stressors fostered a climate of tension accompanied from increased stress or sense of hopelessness, and in turn lead to aggressive behaviours or sometimes to emotional or physical abuse. These results are in line with other studies, which also indicate that there is a group of service leavers, who are adversely affected by the challenges of transition, either because they face more challenges or are less able to overcome them (Cox et al., 2018; Defence Committee, 2018; Docherty-Hughes et al., 2019; HoP, 2016; Iversen & Greenberg, 2009; Kapur et al., 2009; Pinder et al., 2012; Polusny et al., 2011; Samele, 2013).

Similar problems arose in veterans' employment transition. Results indicate that all veterans (even the ones who got managerial jobs) suffered cultural shock, as there was a stark contrast between military and corporate culture. Overall, the main barriers for veterans to find employment and establish themselves were education, skills mismatch, and skill translation. Veterans (mainly the young ones) who did not have advanced degrees or qualifications, tended to be restricted to unskilled or lower positions, which cannot offer the excitement and pride of a military job. Military training provides individuals with excellent skills, such as leadership skills and discipline. Veterans who managed to project these skills correctly to potential employers and explain how their military skills translate to civilian jobs, were able to secure a job or progress doing a job they would enjoy. On the contrary, veterans who were not able to separate themselves from the military, for example, write a CV according to civilian standards and act professionally in an interview, faced many issues in finding employment. These findings match those of other studies which also show that veterans appear to have lower odds of employment than civilians, due to less qualifications or inability to project and use their skills and experience in civilian jobs (Arkenford & FiMT, 2017; Deloitte, 2016; KCMG, 2014; Kleykamp, 2013; Kleykamp, 2006; RBL, 2014a; Robertson & Brott, 2013; Stone & Stone, 2015).

The negative stereotype of the 'traumatised veteran' misconception held by the public or employers with regards to the metal health of veterans still exists (Deloitte, 2016; Poppyscotland, 2015; Prudential Financial, 2012) and in turn hinders employment prospects. It is well-documented that mental health

problems can impede individuals' well-being, but only a minority of veterans suffer from mental health problems (Crone et al., 2020; Defence Committee, 2018; Demers, 2011; Docherty-Hughes et al., 2019; MoD, 2018). Findings suggest that the employment transition and reintegration to a corporate environment is a more complex, multidimensional problem. This is in line with older and recent publications on the topic, showing that despite the ongoing improvements, barriers still exist during employment and economic transition (Arkenford & FiMT, 2017; Deloitte, 2016; FiMT, 2013; Stone & Stone, 2015). The military environment is structured based on a command and control operations model, where discipline and rigidity are important values. Corporate environments are usually structured based on a collaborative model and the lack of leniency could lead to morale problems. Civilian employers may look for creative, flexible individuals who can also think outside the box, something that military personnel are not trained to do. Current results also show that co-worker interactions can be challenging, with both parties (i.e., veterans and civilians) having difficulties to co-operate. Veterans are used to sharing a bond in beliefs and strong military values, having selfless loyalty to their team. What was highlighted in this study was the different approach to work driven by selfish interests and the inability to share the same values (Millward, 2005; Rothmann et al., 2015).

A collaborative effort among the MoD, potential military-friendly employers and veterans as individuals, is necessary. It is not only about supporting veterans with securing short-term employment but also develop long-term, strategic objectives that lead to veterans' holistic professional development.

The MoD should engage and improve communications with organisations, raise awareness and educate potential employers to recognise the skills and talents of veterans and eliminate discrimination against them in recruitment process because of mental health stigma and misconceptions. Employers who value ex-military personnel and decide to give them a fair chance to prove themselves should offer internal programmes to educate and assist veterans in making the integration to the corporate culture. The military should better prepare service leavers, especially the young ones, on practical issues such as writing a CV, but also on how to translate their skills and better adjust in a civilian job. Finally, veterans themselves have to be able to recognise and promote their own skills and talents and make a conscious effort to understand and adjust to the civilian workplace.

Ill physical or mental health were well-outlined in the current findings as an additional barrier that hindered their efforts to adjust to and re-shape an identity in the civilian society. Veteran amputees (upper/lower limb loss) or the ones who suffered severe permanent physical injuries (traumatic brain injury/spinal cord injury) had to first come to terms and cope with the long-term impact of the injuries. Research on the psychological and functional outcomes in veterans after major physical trauma has increased rapidly in volume due to the conflicts in Iraq and Afghanistan (Coleman et al., 2017). Physical trauma can be progressive and degenerative involving comorbidities, enduring experiences of pain or development of mental health problems, which undermine veterans' health, wellbeing and quality of life (Caddick et al.,

2018; Christensen et al., 2016; De Godoy et al., 2002; Ebrahimzadeh et al., 2016; Ebrahimzadeh et al., 2015; Faraji et al., 2018). Despite the challenging nature of a life-changing physical injury, results suggest that veterans were willing to learn quickly how to do simple or complex everyday activities to achieve a good quality of life. Overall, findings show that combat injured veterans demonstrated high resilience, positive attitude and a sense of pride for their injuries as a result of combat. They managed to achieve a smoother adjustment and decrease the negative impact of their injury in the long-term. Indeed, psychological factors, such as pride for their service regardless of the consequences, that facilitate veterans' adjustment after injury, is sometimes ignored (Morin, 2011).

Mental health problems were a latent and very complex barrier in veterans' adjustment to civilian life. Depression and anxiety issues, either from mild or severe, were common among all veterans. Evidence indicates that veterans with ill mental health have poorer treatment outcomes than civilian counterparts (Murphy et al., 2017). What was highlighted in this study as a major problem was the unawareness and unfamiliarity with mental health symptoms. Veterans demonstrated a passive attitude and suffered in silence by ignoring the symptoms thinking that this situation was normal or unchangeable. Maladaptive coping was employed, including isolating themselves, becoming aggressive or violent, developing unhealthy alcohol drinking behaviours (from binge drinking to alcohol dependence), having suicidal thoughts or attempting suicide more than once. There is extensive literature demonstrating that deployments and combat experience are

associated with increased risk of the mental health problems outlined above (Baker et al., 2009; Currier, Holland, & Malott, 2015; Elder, Ehrlich, & Gandy, 2019; Fear et al., 2010; Hoge et al., 2004; Maguen et al., 2015; Ramchand, Rudavsky, Grant, Tanielian, & Jaycox, 2015; Reeves, Parker, & Konkle-Parker, 2005; Van Winkle & Safer, 2011). Surprisingly, results suggest that even the ones who had an official diagnosis of a mental health disorder demonstrated ignorance regarding their mental health problems and employed the same unhealthy coping strategies. These results point to a need for the armed forces and civilian healthcare system to emphasise more on the recognition and treatment of early warning signs of mental health illness, alcohol misuse or self-harm. Once again, results highlight the need for a collaborative effort between the military and the civilian health care system, ensuring veterans get the right care and treatment in a timely manner.

Findings suggest that the civilian health care system was neither effective nor efficient. Veterans had different experiences in the NHS, depending on their health issues, with the ones having ill mental health facing more challenges. Issues were raised for medical and counselling services. These included inconsistences in waiting times and treatment, lack of tailored services, inability to build bonds of trust due to lack of consistency, or clinicians' unawareness of the military culture and specific problems military veterans may face. Many veterans had to rely on armed forces charities to get tangible and intangible support. These findings are in line with recent reports, indicating that specialist care continues to be time-limited and as a result veterans with the most complex and long-term mental or physical health needs

find themselves alone or dependent on armed forces charities (Crone et al., 2020; Docherty-Hughes et al., 2019; Help for Heroes, 2018), which do not necessarily manage to resolve problems and provide solutions for all veterans and their families. The support of charities is recognised, yet, not all charities that deliver mental health provision adopt statutory guidelines of best practice or standardised principles of veterans' care (DSC, 2017) and not always work together to the full benefit of the veteran community (Defence Committee, 2018; Docherty-Hughes et al., 2019). The effectiveness of conventional therapies was also a controversial issue among the findings. For some individuals it was considered ineffective. For the ones who were willing to open up and try a form of therapy, it was found either neutral or partly effective. It must be noted here though that veterans who found therapy beneficial chose a private practice or were supported by a relevant charity and not NHS services. Indeed, the NHS recognised that more should be done to support a smoother transition from the armed forces healthcare to the NHS, by raising awareness of where veterans should go for help and educating health professionals of the unique issues faced by those from a military background (Bashford et al., 2015; Coleman et al., 2017; NEL, 2016; NHS, 2016). Efforts to improve the services were made with NHS England aiming to transform mental health care for veterans by investing £3.2m in a national complex treatment service (NHS, 2018). The purpose of this funding is to treat more veterans, over a longer period and closer to their home, offering support not only on mental/physical health or alcohol misuse but also on relationships and finances, employment or accommodation. The same question regarding the

reasons why the current strategies for detection and treatment of mental health problems are not effective enough, remains. Indeed, there are veterans who need mental healthcare and are completely failed by the system. In their recent report, The Defence Committee (House of Commons) acknowledged it was a "*scandal"* that in an NHS budget of over £150 billion, less than £10m a year had been allocated to mental health services for veterans (Docherty-Hughes et al., 2019). The system proved itself to be the biggest barrier, despite of all the recommendations from experts and practical interventions to improve the services for veterans. A holistic approach that actively and continuously informs and educates all interested parties (i.e., the Military, MoD, NHS, armed forces charities and military and ex-military personnel) could be the way to successfully address and effectively resolve these issues.

7.3 Social Support

Sources of Support

The buffering effect of various forms of support from different sources and its significant positive impact on veterans' well-being was well-demonstrated in this PhD. Three main sources of support were identified: comrades, spouses/partners and family/friends. These social networks offered veterans emotional, instrumental and informational support. All forms of support were proven extremely valuable not only while veterans were serving but also during their transition to civilian life. Social support played a significant role in veterans' lives during and after the military service and facilitated veterans to cope better with challenges in all aspects of their lives. Social support in varying

forms (e.g., family, friends, community or society), is also recognised in Castro's military transition model as a key factor, which may also affect transition.

Current findings match those of other studies highlighting that support from comrades and group cohesion during service buffer the negative effects of combat exposure, increase resilience and protect against the later development of mental health problems among veterans (Magruder & Yeager, 2009; Prati & Pietrantoni, 2009; Verweij, 2007). The positive impact of comradeship was particularly highlighted among veterans who suffered physical injuries, especially during the hospitalisation, as it decreased feelings of hopelessness and increased emotional strength. Social bonds with comrades can protect and help service members to better cope with emotional distress or physical injuries. At the same time it can entail heavy costs, such as feelings of guilt, when valued comrades are lost during combat deployments (MacCoun, Kier, & Belkin, 2006; Wong, Kolditz, Millen, & Potter, 2003). 'Loss' is central to the experience and psychological consequences of combat; it was highlighted that losing a friend during combat was one of the lowest points in life, even comparing to personal physical injuries. Results demonstrate that the death of comrades haunted individuals who often asked themselves the unanswerable question '*Why him and not me?*'. These findings are in line with the literature, indicating the increased emotional pain after losing a friend in combat and the burden of survivorship that can cause self-blame and self-destruction (Elder & Clipp, 1988; Lee, Vaillant, Torrey, & Elder, 1996; Pitts et

al., 2013). Camaraderie was a key factor that facilitated veterans, directly or indirectly, to manage challenges during and after military service.

The civilian sources of support were valued differently from veterans depending on their family situations or marital status. Veterans who were married or in a relationship considered their spouse/partner as the most important person in their lives. Veterans, who were single valued other sources of support, such us their military friends or family. Regardless of the source or form (tangible/intangible) of support, the experience of being respected, cared about, and loved by the people present in one's life was highly valued. Yet, results indicate that in many cases veterans felt that their family or friends could not understand the unique nature of their problems, making feelings of loneliness and isolation seem impossible to overcome. Indeed, inappropriate forms of support or the lack of it make individuals more vulnerable, for example deterioration of mental health, alcohol misuse or suicidal thoughts/attempts. These findings are in line with a number of research publications in the armed forces (Brancu et al., 2014; DeBeer et al., 2014; Jakupcak et al., 2010; Laffaye et al., 2008; Pietrzak et al., 2010; Pietrzak, Russo, Ling, & Southwick, 2011; Prati & Pietrantoni, 2009; Tsai, Harpaz-Rotem, Pietrzak, & Southwick, 2012) and general population (Abbas et al., 2019; Dadvand et al., 2016; Dodd et al., 2015; Haj-Yahia, Sokar, Hassan-Abbas, & Malka, 2019; McConnell, Birkett, & Mustanski, 2016; Northcott, Moss, Harrison, & Hilari, 2016; Oppedal & Idsoe, 2015; Racine et al., 2019). These studies demonstrate the buffering effects of social support, suggesting that

low social support is associated with depression, anxiety, social problems and low self-esteem.

In particular, spouses/partners were considered as the most important individuals during veterans' transition. Numerous sacrifices were reported by spouses/partners at personal and professional level including, relocation, low job satisfaction and no personal or social time. This appeared to have complex implications on their sense of self and well-being and in turn reduced relationship quality. All these were acknowledged by veterans, who many times emphasised their feelings of regret and guilt for the practical and emotional problems they caused to their spouses/partners. These led to poor stability and functioning of the relationship and caused disruption and additional strain between the couple (Norris et al., 2018). Despite having to consume physical and emotional resources, spouses/partners demonstrated high moral commitment towards their husbands/partners, which in cases restored the balance in the relationship. It was emphasised multiple times by veterans that their spouses'/partners high levels of empathy and the sense of feeling understood was crucial in maintaining a balance in the relationships while trying to tackle their own personal problems and the problems that occurred in the relationship. Indeed, the release of emotional constriction by both veterans and their spouses/partners was an important step in the development of intimacy, trust and emotional attachment (Stafford & Grady, 2003).

7.4 Life Transitions & Sense of Identity

A transition can occur when life events result in change and affect various aspects of an individual's life and their societal roles, which can be disabling for many. More specifically, military transition has been defined as the period of reintegration from military into civilian life and describes the process of change that military personnel undertakes when their military career finishes. The life course evolution of veterans' identity includes: (i) the formation of the pre-service civilian identity (e.g., childhood), (ii) which changes to military identity when the individual identifies themselves as part of the military after enrolment, (iii) which then changes again to post-service veteran identity after leaning the military (Thompson et al., 2017). Developing a military identity during recruit training is a formalised, intense process and the same applies to when service members shape post-military identities when leaving the military. As part of individuals' new 'military identity', strong sense of duty and pride was developed and deeply embedded in individuals' conscience while serving. The emotions of *authentic* pride played a significant role in finding purpose and developing a strong sense of identity while serving in the military, by enhancing self-confidence, productivity and will power (Dyson, 2006). Indeed, the emotion of pride provided immediate and salient feedback on the veterans' social and moral acceptability and their worth as human beings. Apart from enhancing their self-worth, pride encouraged behaviours that increased their inclusion within their social group (i.e., military) (Mascolo & Fischer, 1995). Individuals tend to adopt the identity and behaviours of the groups they belong to, as groups provide them with a sense of belonging in the

social world and in turn their self-esteem is linked with these groups (Tajfel & Turner, 1979). As members of a team - 'a family' as mentioned by many – veterans also conceded success or achievement to the efforts of the group and not just themselves (i.e., group pride) (Delvaux et al., 2016).

Most military personnel resolve identity issues relatively easily, while others have significant challenges in constructing an effective post-military identity (Blackburn, 2016). Castro's military transition model identifies the nature of transition, including military discharge (e.g., predictable or unpredictable), combat history, personal characteristics (e.g., health), expectations and personal preparedness as a key elements that can affect the transition in the long-term (Castro & Kintzle, 2016; Castro, Kintzle, & Hassan, 2014). Indeed, leaving or being rejected from a preferred social group, the military in this case, can disrupt veterans' social identities (i.e. the sense of who they are based on their group memberships) (Tajfel & Turner, 1979) and in turn cause distress or cut them off from material and psychological resources that allow them to live well. As explained before, individuals tend to adopt the identity and behaviours of the groups they belong to, as groups provide them with a sense of belonging. When veterans leave the military and enter civilian society a big gap is created and a loss of identity can occur during the transition from the one group (military) to the new group (civilian society). The loss of a sense of identity was associated with lack of purpose, motivation and loss of pride/emotions of shame which in turn decreases self-image and self-esteem. Experiences of shame can be painful and could be conceptually related to low levels of self-

esteem. In turn, low levels of self-esteem could increase individuals' vulnerability to experience negative emotional states (Velotti et al., 2017). In addition, shame can provoke antisocial behaviours and aggression, which can be viewed as emotion regulation or coping strategies in response to ego threats (Elison et al., 2014). Indeed, the way in which veterans either coped with or defended against shame had important implications (Elison et al., 2006), including different shame-coping styles, such as attack self (e.g., alcohol misuse), withdrawal (e.g., isolating self, avoiding communication), attack other (e.g., aggressive behaviour towards family or other people) and avoidance (e.g., avoiding responsibilities or being proactive) (Nathanson, 1992). Individuals can effectively cope with their transition when they manage to integrate their new social identity with the old. Results indicate that transition and adjustment to civilian life can be particularly challenging for those who have deeply invested in military identities, experienced involuntarily release from service, do not have social resources or experience in civilian society and workplaces, they have developed mental health problems or suffered physical injuries while serving (Robinson et al., 2017). Desirable or undesirable transitional events and chronic stressors can diminish veterans' self-concepts and threaten their personal identities, leaving them vulnerable to experience symptoms of stress (Pearlin et al., 1982).

Transitions take time, and people's reactions change and that is why veterans react differently to the same type of transition. Also, the same individual may react differently at different times in their life. For example, results show that

in the long-term some veterans managed to overcome the challenges and develop a new way of living in the civilian society, opposed to others. There is no right or wrong coping strategy, instead the individual, who flexibly uses lots of strategies will be better able to cope with their transition. Results suggest that veterans who had a more positive approach to life and were more flexible to learn and grow form the negative experiences in life were able to build a stronger sense of self and in turn re-shape a sense of identity. Identifying ways to remain motivated and start seeking for a new purpose in life brought back the lost sense of pride and increased their subjective sense of confidence and self-esteem. Veterans were able to pride themselves again on who they were becoming and be proud of new achievements or efforts made towards that goal. At the same time, the support available at the time of transition was critical to veterans' sense of well-being. Even though veterans experienced pride in response to new accomplishments in civilian life even without others' evaluations, emotional or practical support and positive feedback from others enhanced their pride experience, re-creating the lost 'sense of belonging'. Indeed, as discussed in the previous sub-section (7.3), the quality or the lack of emotional or practical support during transition and in the long-term, either from family and friends or civilian healthcare services and Armed Forces charities, facilitated or impeded (respectively) the transition process.

7.5 Beyond Conventional Therapies & Healthcare

As discussed previously, there is a lack of a holistic approach that involves various opportunities and alternatives activities, which will allow veterans to

choose or combine activities and programmes that best accommodate their needs, help them re-shape a new identity, find a new strong purpose and maintain their motivation in the long-term. Resettlement programmes and clinicians who work with ex-military population should be well-informed and be able to provide options or develop tailored plans to facilitate transition to civilian life.

(ii) Competitive Motorsport

The question of how physically and psychologically traumatised men can successfully negotiate the intersection of normative expectations of masculinity and trauma is still under discussion. In order to explore the complex issue of trauma and develop a better understanding of how men can recover or reconstruct their masculinity, can be through alternative ways, such as physical activity. Sport is a culturally constructed phenomenon in western society, linked to physical strength and ability (Easton, 2014; Manderson & Peake, 2005; Sandahl & Auslander, 2005). As Connell (1995) reported "*sport has come to be the leading definer of masculinity in mass culture"* (p.54), as athletes embody the physical ideal of health. Also, physical activity can play a significant role in the management of mild-to-moderate mental health problems, such as depression and anxiety (Paluska & Schwenk, 2000), which are usually the most common issues among ex-military personnel (Pietrzak, Pullman, Cotea, & Nasveld, 2012; Vogt, 2011). Traumatised men, and especially male military veterans for whom masculinity is deeply embedded in their conscience and identity shaped while serving, may desire to reinvent themselves through sport. Indeed, research in both male civilian (Courtenay,

2000, 2004; Murphy, 2019; Robertson & Kilvington-Dowd, 2019) and military populations as discussed in Chapter 1 (Barrett, 1996; Lee, 2016; Reit, 2017) indicates that men are reluctant to seek help from healthcare professionals in fear of being considered weak or undermining their dense of masculinity. These unhealthy attitudes can increase men's vulnerability and lead to unhealthy outcomes, such as feelings of shame and inadequacy, violent behaviour, suicidal thoughts or attempts, depression and alcohol misuse (Courtenay, 2004; Lynch et al., 2018; Searle et al., 2019; Sloan et al., 2015). Nevertheless, aspects of masculinity have been shown to be related to health-promoting behaviours, such as working out or avoiding alcohol (Sloan et al., 2015; Sloan et al., 2010; Smith, 2013). Physical activity is the key factor of health maintenance and chronic disease prevention for individuals with or without a disability and the numerous physical and psychological benefits associated with exercise are well outlined in the literature (Vartanian et al., 2012). It is also well-documented that non-pharmacological therapies, such as physical activity interventions and sport are beneficial for cognitive function, mental and physical health to general population of any age group (Carvalho et al., 2014; Groot et al., 2016; Sahlin & Lexell, 2015; Van Raalte & Brewer, 2014). Such interventions can be an effective alternative or add-on option to current pharmacological treatment as they promote values and enhance the well-being and psychosocial health of people with disabilities and/or mental health issues (Hefferon et al., 2013; Ginis et al., 2012). Additionally, sports offer individuals the opportunity to find enjoyment, express intrinsic motivation and

provide potential space to renew self-esteem that may be lost in other areas of life, such as work or personal relationships (Hawkins & Lynne, 2011).

Military veterans are individuals who can be motivated by moderate or intense physical activity that requires practical skills (Poulsen et al., 2015) or sport that may involve high levels of adrenaline, competition and achievement (Betthauser et al., 2017; Lee & Uihlein, 2019). There are different alternative interventions aiming to help and motivate military veterans or be used as an alternative rehabilitation plan; for example, nature-assisted approaches and Wilderness Experience Programmes (e.g., climbing, hiking, kayaking, adventure courses) (Poulsen et al., 2015), or sport (Caddick & Smith, 2014). All of them have been proved beneficial, each one for various reasons, including opportunities for reflection, socialising, learning new skills and increased general motivation for living. Participation in CM also had a positive impact on veterans, but what was considered to be unique about this sport was that most of these key elements were combined. It was an opportunity to develop a holistic self-care plan, enhancing their physical health, psychological and social well-being. The similarities between the procedures and values of CM and military training, such as team spirit, adrenaline rush and competition, were key elements of the sport which allowed veterans to feel comfortable, demonstrating positive attitude to change. Both CM as a sport and group cohesion among the members of the charity, directly benefited veterans. The importance of socialising in a non-clinical environment and competing with fellow veterans who had severe or minor physical injuries, but also able-bodied civilians was highlighted among the findings. Results also show an increase in

body image satisfaction, healthy eating and exercise attitudes. Veterans were able to understand their strengths, improve their weaknesses and start re-shaping an identity as part of the civilian society. Improvements in mental health symptoms as well as enhanced self-esteem, confidence and great sense of achievement were well-outlined in this study. Since physical activity and sport are included among the growing research on alternative interventions to support military veterans, they deserve serious consideration as part of the treatment regimens to improve veterans' mental and physical health and facilitate their transition to civilian life.

(i) Narratives & Storytelling

The narrative approach enables individuals to present their experiences, thoughts, and feelings as a story and in turn allows the researcher to obtain a deeper understanding of participants' lives and gain access to the social and psychological outcomes of participants' traumatic experiences (Murray, 2008). A positive aspect of the narrative approach is that it can be an empowering experience as a process. It can be 'therapeutic' in its own right (different from clinical model approaches), as it allows traumatised individuals to view their experiences as separate from themselves. At the same time it makes it easier to recognise, understand and protest its influence by establishing a rapport between author and listener/reader (Riessman, 1993; White & Epston, 1990). Identity in adulthood is an inner story of the self, which connects the reconstructed past, perceived present, and anticipated future to provide a life with unity and purpose. Narrating life experiences is a complex process that

not only reflects, but also creates modes of meaning-making. Beyond the content of life stories, the narration per se is essential to understand narrative identity. During this process, the identity is crafted; what and how individuals say and repeat while narrating, indicates who they are and where they stand in society. Creating a coherent sense of identity can lead to self-development as it helps the narrator to obtain a better understanding of self (Fivush et al., 2017). One way to improve psychosocial well-being and rebuild identity is through developing one's life story. The narrative identity is a way to process and elaborate on negative/traumatic life experiences, something that can affect pathways of personality and identity development.

The application of NLI as a research tool indicated that there are multiple benefits for participants, but also proved to be a useful interview technique helping the researcher to gain an in-depth understanding of veterans' life journeys and the ways memories and experiences are connected. The use of storytelling can be a powerful technique with 'therapeutic' significance that has previously been documented in the literature (Cook et al., 2004). Through this process, individuals can choose to share positive memories but also integrate negative experiences into their existing autobiographies. Storytelling can be an opportunity to externalise any feelings, which might otherwise prove detrimental to their well-being if they remain hidden. The process of storytelling has the ability to engage individuals' emotions and subsequently prompt emotional responses and new ways of understanding their lives (Denning, 2002). Indeed, narrating seemed to have some 'therapeutic' effects for some individuals; these came through the process of emotional

engagement whilst narrating their personal stories, but also the subsequent re-interpretation of important life events in more adaptive ways. It was an opportunity to find new meanings and facilitate a process of positive change or the will to work towards positive change, through challenging existing maladaptive views or interpretations of events. It allowed participants to achieve coherence in their life story, subjective perspective on what they have experienced while developing integrative meaning and motivational themes. It enabled them to recognise the changes in the emotions and interpretations of life events since they occurred, which is an indication of personal growth, redemption and integrative meaning through the narration of perspectival change. Overall, NLI was an opportunity for veterans to present both their positive and negative/traumatic life experiences, thoughts, and feelings, while at the same time being encouraged to interpret and elaborate on behavioural and emotional patterns. In turn, this allowed the researcher to obtain a deeper and rounded understanding of participants' lives, rather than solely in traumatic experiences by exploring social and psychological outcomes as well as the implications on identity and self.

7.6 Conclusions

Transition to civilian life is a highly complex process which is shaped by pre-military and military experiences and individuals' unique personality, mental and physical health needs and general values and approaches to life. The HMoMT presented here was developed based on veterans' unique and subjective experiences, indicating that the double transition (i.e., from civilian to military and from military to civilian life) follows a cyclical pattern of

'seeking, finding, losing and re-seeking motivation and a strong purpose in life', which is inextricably linked with the need for a stable sense of identity. Re-organising the self-concept and integrating new identities into the sense of self can be a challenging process, especially during transitions that are on a high level of identity disruption. Despite the great efforts made by the MoD, civilian healthcare services and armed forces charities, significant barriers remain, and veterans and their families continue to face difficulties in all aspects of their lives. Among the potential reasons for the continuous setbacks could be (i) the lack of focus on how important, yet challenging, it is to always maintain a strong life purpose and a stable sense of identity, and (ii) the lack of a holistic model of rehabilitation and resettlement, which informs all interested parties (i.e., service members and their families) and ensures that tailored support is offered covering not only mental and physical health but also, all aspects of personal, employment and economic transition.

The two independent studies explore two alternative interventions, storytelling (NLI) and sport (CM) aiming to generate targeted recommendations for future research and practical implications. Resettlement programmes and clinicians who work with ex-military population should be well-informed and be able to provide options and develop tailored plans to facilitate transition, but also allow veterans to re-shape a new sense of identity and find a purpose in life that will keep them motivated in the long-term. Clinical interventions can promote involvement in safe, affordable and exciting physical activities or team sport, which will consider relevant individual

characteristics, such as physical limitations, coping styles or severity of symptoms and accomplish adaptive aims for the veterans. Future research on this area should identify the long-term economic and cost-benefit implications of recommending physical activity/sport, which will be particularly useful for the improvement on the rehabilitation and resettlement plans of the military and NHS. Also, practitioners, such as Clinical Psychologists or therapists should be educated and aware of the military culture and the unique and complex process of transition. They should allow veterans to develop their own story, which includes positive apart from negative/traumatic experiences and allow for meaning-making to happen through reflection and growth during this process. Military personnel come under numerous pressures throughout their military career that can have direct and indirect negative impact on them but also their families. Military spouses play a key role in buffering all the negative effects of transition (e.g., emotional distress, ill physical and mental health) and enabling veterans to reintegrate into civilian life and workforce. The third independent study explores an under-researched topic, which is spouses'/partners' experiences and perceptions of military transition. The study indicates the need for continuous improvements and additional support from health care services (e.g., NHS, armed forces charities), to reduce practical and logistical barriers in seeking help. Psychoeducation, raising awareness, sharing information and offering targeted guidance are necessary for spouses/partners to successfully navigate life after transition and effectively accommodate veterans with ill mental or physical health.

It is acknowledged that this is a qualitative research project and hence no claim to statistical representativeness is made, but rather it is assumed that findings can reflect valid descriptions of sufficient depth and contribute to the development of conceptualisations of the military transition as a phenomenon. Future research should continue exploring these topics in detail to establish alternative, yet effective ways to support veterans and their families during their transition and in the long-term. It is more important than ever, for future research to also focus on underrepresented groups, such as female veterans, LGBT veterans and male spouses or LGBT partners. Details regarding limitations and specific future research recommendations can be found in the respective chapters.

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Appendices

Appendix 1 - HADS

Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

Scoring:
Total score: Depression (D) _____ Anxiety (A) _____
0-7 = Normal
8-10 = Borderline abnormal (borderline case)
11-21 = Abnormal (case)

Appendix 2 - PCL-5

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Appendix 3 - Ethical Approval

The University of Nottingham

E-mail: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine and Health Sciences

Research Ethics Committee
C/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

28th February 2017

Miss Danai Serfioti
PhD Student
c/o Dr Nigel Hunt
Associate Professor
Division of Psychiatry and Applied Psychology
Room B19 International House
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear Miss Serfioti

Ethics Reference No: R100217– **please always quote**	
Study Title: The benefits of competitive motorsport on injured armed forces veterans and troops.	
Chief Investigator/Supervisor: Dr Nigel Hunt, Associate Professor, Psychiatry and Applied Psychology	
Lead Investigators/student: Danai Serfioti, PhD Student, Psychiatry and Applied Psychology	
Type of Study: PG project, qualitative/quantatitive, development of technique	
Proposed Start Date: 01/03/17	**Proposed End Date:** 30/09/2019 30 mths
No of Subjects: 25-30	**Age:** 18+years
School: Medicine	

Thank you for submitting the above application which was considered by the Committee at its meeting on 10th February 2017 and the following documents were received:

- FMHS REC Application form and supporting documents version 1.0: 30.01.2017

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A favourable opinion is given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is notified of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

University of Nottingham
UK | CHINA | MALAYSIA

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
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3 November 2017

Miss Danai Serfioti
PhD Student
c/o Dr Nigel Hunt
Associate Professor
Division of Psychiatry and Applied Psychology
Room B19 International House
Jubilee Campus
Wollaton Road, Nottingham
NG8 1BB

Dear Miss Serfioti

Ethics Reference No: R100217– **please always quote**	
Study Title: British veterans' and their partners' narratives of transition to civilian life: Alternative interventions to resolve challenges. (Old Title: The benefits of competitive motorsport on injured armed forces veterans and troops)	
Chief Investigator/Supervisor: Dr Nigel Hunt. Associate Professor, Psychiatry and Applied Psychology	
Lead Investigators/student: Danai Serfioti, PhD Student, Psychiatry and Applied Psychology	
Type of Study: PG project, qualitative/quantatitive, development of technique	
Proposed Start Date: 01/03/17	**Proposed End Date:** 30/09/2019 30 mths
No of Subjects: 25-30	**Age:** 18+years
School: Medicine	

Thank you for notifying the Committee of amendment no 1: 24.10.2017 as follows:

- Change of Title
- Additional Study to include veterans' wives/partners narratives as the importance of family and social support is indicated from the ongoing interviews with veterans. The protocol originally approved will be used.

The following revised documents were received: Participant Information Sheet; Consent Form; Demographic Form; Interview Protocol; E-mail invites to Charities V1.0: 31.10.2017.

These have been reviewed and are satisfactory and the study amendment no 1: 24.10.2017 has been given a favourable opinion.

A favourable opinion is given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is notified of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix 4 - NLI Interview Protocols

Interview Protocol Veteran Study

Introduction:

This is a story of your life

I am going to ask you not only about what happened in your life but how events made you feel and how you coped with them.

There are no right or wrong answers

The purpose of this interview is not therapy but it might make you feel better afterwards

The interview is for research purposes only

Everything you say is voluntary, anonymous, and confidential.

Recorded – I also take notes

Do you have any questions?

Basics

Age – what age did you join the Army/Navy/Air Forces/Marines?

How long did you serve for?

Where did you serve?

- **Stages of your life**

Perhaps you could start to think about the most important events in your life. We can do this in three stages

- Before you joined the service
- While you were in the Army/ Navy/ Air Forces/ Marines
- Since leaving the service and becoming a veteran

We're going to focus on both the positive and negative events in your life during these times.

Let's take these one at a time. Can you tell me about what happened during this time and also how the events made you feel and how you coped with them?

1. **Before joining the service**

   What was life like?

Memories of life before joining/ childhood – remembered feelings, thoughts, beliefs

Parents, family, friends

School, work

Highlights of life – what were the best and worst times of your life

2. <u>Joining the Army/ Navy/ Air Force/ Marines</u>

Why did you decide to join XXX?

- What happened
- Explain in full the reasons
- Feelings/emotions, thoughts, behaviour (FTB)
- What happened to others?
- Impact on self (FTB)

Where did you serve? How long were you there for?

Details, FTB, who with, what happened

How did you feel about serving there?

How do you feel now – how does it still affect your life?

In what ways?

Do you have any positive or negative memories from your time in XXX?

What were the worst and best times of serving in XXX?

Support

Did you get help from anyone when left the services?

Organisations, people (practical support?)

Any psychological support

Did your family or friends help in any way?

Do you still get any help?

Were there any barriers which stopped you from seeking support you needed? (i.e., stigma in military mental health).

Professional life

Challenges of employment transition

Coping

How did you cope with what happened?

How do you cope now – have things changed?

Change of military identity/culture

What was the culture of the Armed Forces like?

How does this compare to civilian culture/society?

What do you miss about being in the Forces?

Do you still feel part of the Forces in any way?

Change of identity

How have you changed as a result of being in the Armed Forces?

What about the people around you

Friends, family?

How do other civilians treat you?

How do you feel about that? / What would you like to change?

Do you feel part of a civilian identity or more a military one?

Do you think you have fully transitioned? And if not, what do you think needs to happen to make the transition possible?

What are you doing now?

Work, school, volunteering, etc

Are you happy with this work?

What would you prefer to be doing?

How do you think, feel, behave?

Beyond being a Veteran

Reflecting on your life

What has been your biggest challenge/difficulty in life (if veteran next biggest)?

How did you deal with it?

What impact does it have/ Did it have on your life?

What does it mean to you today?

Do you think it changed your life?

Health

Tell me about a health challenge, you or family member

How did you deal with it?

Healthcare system, coping, support

Longer term impact?

Loss

What was your biggest loss in life? – details – how feel/act/think, coping, support

How do you feel about this today?

Failure or regret

What has been your biggest failure or regret in life?

Details, coping, actions, feelings, thoughts, coping, support

General beliefs and values in life

What are your Ethical and moral views about life?

Beliefs, religion/spirituality

Political beliefs, views about social issues

Why? Explain all, where they come from, impact on life now and in the future

Has anything you have done wrong influenced your views?

Have these views changed over time? Explain

What do you think is the single most important value in human living?

Anything else re beliefs and values, philosophy, approach to life?

Future

What do you hope to achieve, why, how?

Dreams / Life project

Interview

Any comments, thoughts, feelings about the interview

Affected you in any way?

Any comments or questions?

THANK YOU

Second Interview Protocol – Questions

- What impact has doing the interview had on you?
- How did you feel after the interview? / How do you feel now?

- Do you think there were any benefits to doing the interview?
- Any disadvantages?
- Are you happy that you did the interview? / Why?

- Do you think it would be better to do it differently next time? i.e. would you want to write your story first before I ask you any questions?

- Did you think that any of the questions weren't relevant or you didn't want to answer them?

- What do you think about the whole process?
- Would you do the interview again?

- How useful did you find doing the interview?

  On a scale of 1 to 10, with 1 being not useful and 10 being very useful, what would you rate it?

- Did you find the interview difficult or stressful in any way?

- What was your favourite and least favourite part of the interview?

- Any other comments to help us improve for next time?

Thank you for taking part in this study.

Appendix 5 - CM Interview Protocols

a. 1st interview

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

KartForce Veterans' Interview Protocol

Introduction

This is an interview about the story of your life, with a focus on the reasons you joined the armed forces, your experiences in the armed forces, and subsequent events. I am interested not only in what happened but how events made you feel and how you coped with them. I am interested in hearing your story, as you remember it. The story is selective; it does not include everything that has ever happened to you. Instead, I will ask you to focus on a few key things in your life. There are no right or wrong answers. Instead, your task is simply to tell me about some of the most important things that have happened in your life and how you imagine your life developing in the future.

The purpose of this narrative interview is not to figure out what is wrong with you or to do some kind of deep clinical analysis! Nor should you think of this interview as a "therapy session" of some kind. The interview is for research purposes only, and its main goal is simply to hear your story. Everything you say is voluntary, anonymous, and confidential.

Please do not hesitate to ask me to stop the interview and recording at any time.

With your consent, the interview will be digitally recorded.

Do you have any questions?

1st Interview

Outline of life in chapters

Imagine your life was a novel. Can you describe the main chapters of your life? What is contained in a chapter is up to you. It is your life story.

Armed Forces

Before joining the armed forces: Why did you decide to join armed forces? Can you tell me more about your Armed Forces service?

Being in the armed forces: Can you tell me more about your experiences in the Armed Forces? Things you enjoyed, things that disappointed you. Did you regret it?

Injury: Tell me about the impact of your injury; not only the actual experience, but how you felt at the time, when you were recovering, and now. What impact does the injury have on your life now? How were you motivated to recover?

Help Received (in the armed forces): What kind of help have you received regarding your psychological and/or physical trauma? What help did you receive in the armed forces?

Transition and resettlement issues from military to civilian life - Reshape identity

***Personal life - Family, friends and comrades*:** What role have families, friends and comrades played in your recovery? Details.

***Professional life*:** Do you work? Do you have specific aspirations, things you want to achieve in your professional life? What type of difficulties did you face in the workplace (e.g. as a result of your injury)?

Impact of psychological and/or physical trauma: Please describe your current situation. What do you feel? Are you happy or depressed? What impact this health crisis and/or physical injury or challenge has had on you and your life story after leaving the armed forces.

Help Received (after the armed forces): What help did you receive and what help after leaving the armed forces? Are you still receiving any form of help (e.g., therapy, counselling)? Details.

KartForce: Why did you choose Kartforce in the first place? Explain in detail what role KartForce has played for you. In what ways has it helped? How has it not helped?

Thank you for this interview. Do you have any thoughts and feelings about the interview? Has it affected you? Do you have any other comments about the interview process?

b. Follow-up Interview

Follow-up: KartForce Veterans' Interview Protocol



Introduction

This is a follow-up interview about the story of your life and the questions will be chosen based on you previous answers. The main focus is if and in what ways competitive motorsport and Kartforce itself as a charity play a significant role in improving your life.

Everything you say is voluntary, anonymous, and confidential.

Please do not hesitate to ask me to stop the interview and recording at any

time.With your consent, the interview will be digitally recorded. Do you have any

questions?

Reflection

Areas to address:

- Did/Does competitive motorsport helped you in your transition and resettlement from military to civilian life? How? Why?
- Did/Does Kartforce as a charity support you with problems you may face or offer you guidance? And how?
- What keeps you at Kartforce? Are you member of any other charity or do you attend therapy?
- Depending on the participants:
    - Why did you decide to stop competitive motorsport/ leave Karforce? Do you miss it?
    - What motivated you to take competitive motorsport seriously and move to a different organisation/charity?
    - What keeps you in Kartforce?
- What else do you do this period of time that helps you?
- Since the last interview did you have any psychological help (e.g., counselling, therapy, drug treatment)?
- Is there anything else you would like to try (e.g. activity)? / What else would you like to do if you had the chance?

Thank you for this interview. Do you have any thoughts and feelings about the interview? Has it affected you? Do you have any other comments about the interview process?

Appendix 6 - Spouses/Partners Interview Protocol

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Interview Protocol

Introduction

I am interested in the changes that have occurred in all aspects of your personal and professional life since your husband left the armed forces. The purpose of this interview is not to figure out what is wrong with you or to do some kind of deep clinical analysis! Nor should you think of this interview as a "therapy session" of some kind. The interview is for research purposes only, and its main goal is simply to hear the changes that occurred in your life. Everything you say is voluntary, anonymous, and confidential.

Please do not hesitate to ask me to stop the interview and recording at any time.

With your consent, the interview will be digitally recorded. Do you have any questions?

Areas to address:

Personal life:

- Changes in your everyday life
- What did you do to adapt to the new situation?
- Challenges you had to cope with, regarding the relationship.

Professional life:

- Difficulties and changes in your professional life (e.g. quit your job, work part-time).

What do all these changes and challenges in your personal and professional life mean to you (as an individual but also as woman and a wife/partner?)

Thoughts and recommendations:

- Feel free to express your thoughts regarding ways military, NHS, or other professional bodies could help and educate not only veterans' wives/partners' as individuals, on how to effectively support them, but also ways the couple could overcome difficulties.

Thank you for this interview. Do you have any thoughts and feelings about the interview? Has it affected you? Do you have any other comments about the interview process?