Lived Experiences and Weight Management: Being Within, and Moving On from, the Military

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CONTENTS

APPENDICES

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

AF	Air Force
BMI	Body Mass Index
CBT	Cognitive Behavioural Therapy
GP	General Practice
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
PTSD	Post Traumatic Stress Disorder
RTC	Randomised Treatment Control
WMP	Weight Management Programme
UK	United Kingdom
USA	United States of America

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DECLARATION

This thesis was carried out under the supervision of Dr Helen Liebling-Kalifani, Lecturer-Practitoner in Clinical Psychology, Coventry University and Dr Eve Knight, Course Director, Coventry University. Apart from these collaborations the following document is a product of my own. This thesis has not been submitted for a degree at any other university.

SUMMARY

Chapter one adopts a systematic review methodology in order to identify relevant evidence concerning the clinical effectiveness of weight management programmes in the military. It explores the success of such programmes that adopt cognitive-behavioural components as part of their treatment approach as opposed to standard care offered by the military. The paper also offers areas for further research, particularly focused on the need for more longitudinal evidence of the success of these programmes and the longer term outcomes for an individual's career.

Chapter two presents the empirical paper of the thesis. It describes a phenomenological qualitative study of UK army veterans' lived experiences of transition from military to civilian life. It explores how veterans have perceived the challenges of this transition and their experience of the support they have received from various services. Analysis revealed three major themes that captured the lived experiences of these veterans; centred on the consequences of leaving the army, surviving initial civilian life and reconstruction of an identity as a veteran.

Chapter three presents a reflective paper that offers insights into the research journey of the main author and reflections of being on a clinical placement within a community mental health team for the Ministry of Defence. It was found that this was an asset in understanding the applicability of research findings to an everyday clinical setting. This paper also offers experiences and reflections of being a woman in a patriarchal multidisciplinary team; many of whom served in the British army themselves.

CHAPTER ONE:

LITERATURE REVIEW

THE CLINICAL EFFECTIVENESS OF MULTIFACETED COGNITIVE-BEHAVIOURAL WEIGHT MANAGEMENT PROGRAMMES IN THE MILITARY

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1.0 Abstract

The main objective of this literature review was to systematically evaluate the research which investigated the clinical effectiveness of multifaceted cognitive-behavioural weight management programmes for the military. A total of eleven studies were identified from the literature search. The reviewed evidence demonstrated successful weight loss outcomes for military personnel who had attended a multifaceted weight management programme, this included programmes with a significant cognitive-behavioural component. Furthermore, the reviewed studies, which adopted randomised control designs, were identified as having more positive outcomes with regards to weight loss than the usual military care procedure. It does however remain unclear as to whether, after the completion of a programme, the personnel met the mandatory military weight standards and then departed from weight monitoring procedures. Clinical implications have arisen from the presented evidence, suggesting that the integration of a multifaceted programme would complement the current weight management interventions in the military. Future research could concentrate on the long-term reviewing/monitoring of the maintenance effects of such programmes, in order to map the trajectory course of weight management for military personnel.

1.2 Introduction

Achieving and sustaining a healthy weight is an important aspect of maintaining a balanced lifestyle as being overweight can have various and significant consequences. This paper will firstly provide an overview of the predominant themes in the existing weight management research, with regards to the general population; it will then progress to consider their implications within a military context.

1.2.1 The prevalence of obese/overweight adults in the general population

The World Health Organisation (WHO) defines being overweight or obese in terms of the degree of abnormal or excessive fat accumulation that may impair health (WHO, 2013). Prevalence statistics are provided below; these statistics examine the number of people/cases in a given population with a disease/illness at a specified time and include both new and existing cases (Foresight 2007). The data below demonstrates a 'snap shot' as to how many people in the UK and USA are currently overweight and/or obese in identified years. The United Kingdom's (UK) Department of Health (DoH) reported that in 2013, in England, over 61% of adults were overweight or obese (DoH, 2013). It is important to note that prevalence statistics can only show us what is happening at one point in time but provides a good way to indicate the burden of disease in a population.

In the United States of America (USA), Ogden, Caroll, Curtin, McDowell, Tabak and Flegal (2006) reported that in 2004 66% of the adult population in

the USA were overweight and 32% were classified as obese. Given the high prevalence proportions reported above and the associated health risks; obesity is identified as the fifth leading risk condition for global deaths (WHO, 2013). It is important to review the steps which may be taken to ameliorate this increasing risk factor.

The most commonly used measure for classifying whether someone is overweight or obese is the Body Mass Index (BMI). The WHO (2013) defines a BMI greater than or equal to 25 as being “overweight”, whilst a BMI greater than or equal to 30 is classified as “obese”. This index is determined by dividing a person’s weight, in kilograms, by the square of their height, in meters; thus, BMI = kg/m^2.

1.2.2 Weight loss interventions within the general population

The reported costs associated with overweight and obese individuals, has prompted an increased focus on the promotion of healthy living and weight management treatment programmes (Kopelman, 2007). Popular commercial weight loss programmes focus on a “one size fits all” approach whereby dietary and nutritional information are the main intervention. In the UK for example, Weight Watchers and Slimming World are commonly utilised; these programmes have been found to reduce users’ weight at a moderate level. To illustrate, a study by Ahern, Olson, Aston and Jebb (2011) examined weight loss in a Weight Watchers National Health Service (NHS) referral scheme; they found that a third of all commenced referrals resulted in weight loss of at least 5% initial body weight. However, this study only investigated a

twelve-week programme and should therefore only be considered a relatively short intervention duration. Research suggests that in many cases the weight lost during behavioural or pharmacological treatments is regained after the treatment ceases (Franz et al., 2007; Dansinger, Gleason, Griffith, Selker, & Schaefer, 2005.

On the other hand, individually structured and tailored weight management programmes which adopt more cognitive-behavioural strategies can help to provide understanding of the reasons behind overeating and gaining weight. Many operational definitions of Cognitive-Behavioural Therapy (CBT) exist; as such, Kazdin (1978) defines CBT as a treatment that attempts to change behaviour by altering thoughts, interpretations, assumptions and strategies of responding. Furthermore, a meta-analysis of psychological interventions for overweight and obese individuals, by Shaw, O'Rourke, Del Mar and Kenardy (2006), found that within 36 worldwide randomised controlled clinical trials, the use of CBT strategies were deemed to be successful in the treatment of obesity. In particular, such strategies when combined with a diet/exercise intervention increased weight loss compared with diet or exercise alone. A typical CBT treatment programme aims to support the individual to establish a diet and exercise regime, whilst exploring the maintenance of food behaviours, e.g. comfort eating. This is achieved by examining the unhelpful thoughts, core beliefs and feelings that may influence these behaviours (Kopelman, 2007). The skills and techniques utilised in a CBT weight management programme may include: stress management, which can help

with overeating caused by anxiety or boredom; a food diary that gives the individual insight into both their eating patterns and emotions, this provides a demonstration of the link between thoughts, emotions and behaviours and helps to challenge unhelpful thoughts about weight and dieting (Davis, 1996).

The UK's National Institute for Health and Care Excellence (NIHCE, 2006) developed guidelines which advocate a "multi-component intervention" for weight management, including behavioural interventions. Evidence shows that when physical activity is coupled with healthy eating it has a bigger effect on weight loss than interventions that solely focus on healthy eating (Goodpaster, 2010). Whilst there is no specific mention of adopting a cognitive-behavioural approach to the management of obesity, within these guidelines, it is recommended that strategies are used to modify and restructure cognitions (NIHCE, 2006). These multifaceted interventions represent a shift away from the commercial one-size-fits-all approach, as these new interventions have been shown to have more long-term positive benefits on an individuals' health (McDonald, 2009). Furthermore, by addressing an individual's common misconceptions about meals, these strategies can further assist in producing a real lifestyle change rather than a quick fix diet, which is not achievable in the long-term (McDonald, 2009).

Whilst for many individuals being overweight and obese has a significant impact on their physical and psychological health, it may not affect other areas of their life, such as their employment. In some populations however, being overweight is not only a hindrance to individual health but also to long-term career progression. To illustrate, being overweight is potentially

problematic for people in the military as being overweight is likely to have a detrimental impact on their career progression (Peterson, Talcott, Kelleher&, Smith, 1995).

1.2.3 The prevalence of obesity in the military

Bray et al. (2006) report that clinical rates of obesity, based on a BMI of 30 or more, more than doubled between 1995 and 2005 for USA military personnel; obesity is now said to be prevalent in 12.4% of the USA Armed Forces. Equally, self-reported data on the weight of military personnel demonstrates that 57% of individuals are overweight, as defined by the WHO (2013). In the UK Armed Forces, a study by Fear, Sundin and Rona (2011) found a 13% prevalence rate of obesity, in addition 44% of individuals were deemed to be overweight. These UK statistics mirror the USA Armed Forces results, but they are still lower than those found in the civilian population. Nonetheless, Fear et al. (2011) still acknowledge that these rates should be a cause for concern for the military.

It is important to consider these prevalence statistics with caution, amid concerns that the use of the BMI, as an operational diagnostic tool, is inconsistent (Friedl, 2012). The BMI is a measure of overall weight and does not account for, and is unable to distinguish between, fat-free muscle mass or bone (Friedl, 2012). For example, it can overestimate fatness amongst those who are muscular (Prentice & Jebb, 2001). This is a concern as the WHO's (2013) definition of being overweight or obese is based on fat

accumulation only. In fact, the statistics may actually mean that soldiers are getting “more muscular” rather than “fatter”.

Nonetheless, military services claim to offer a sound rationale for their development of weight controlled standards (Department of Army, 1986). The body image of military personnel, in terms of size, composition and appearance, appears to be a multifaceted issue. For psychosocial reasons, the military embraces a policy whereby appearance is incorporating in the real and perceived association of physical performance capabilities. The focus on operational deployment is for individuals to at least look like they are ready to fight as a well-built invading force (Friedl, 2012). To achieve this objective, the military enforce weight and fitness standards to not only promote but guarantee a physically capable workforce. These standards provide a core ethos for retention and promotion opportunities within the military; as a result, they are highly valued by active duty personnel (Peterson et al., 1995). Furthermore, repeated failure to meet the military standards could result in the reduction in rank or hinder the promotion opportunities for personnel (Peterson et al., 1995).

1.2.4 Weight management programmes in the military

The development of weight control programmes in the military has paralleled the general increased societal concern about health, physical fitness and a trim appearance (Polivy & Herman, 1987). It is now mandated that military personnel in both the UK and the USA attend weight management programmes if weight standards are not met. Each branch of the armed

services has developed its own “Maximum Allowable Weight Chart” to screen every member of the military on a bi-annual basis (Nolte, Franckowiak, Crespo,& Andersen, 2002). This chart also includes BMI scores and, although these differ slightly for men and women and for the branch of service, on average they are in line with the guidelines issued for the general population whereby anything above a BMI of 25 is considered overweight.

According to Davis (1996), the standard weight management programmes in the military consist primarily of weight monitoring, coupled with offering some nutritional information. Furthermore, service personnel are reserved from promotion until the weight standards are met. Promotion is generally highly valued by most military personnel (McNulty, 2007), so the bi-annual weigh-in to enforce weight standards creates significant stress for military individuals. As a result, military members have been observed to engage in extreme eating disorder behaviours in order to meet their weight requirements, including self-induced vomiting and the use of laxatives (Peterson et al., 1995).

As established in the literature for the general population, the problem of weight loss maintenance is also a key concern for the military, with individual based counselling proving to be more successful for long-term positive weight loss outcomes (Davis, 1996). This issue, coupled with the increased risk within the military population of eating disorder behaviours, has led to the argument for a more comprehensive programme of weight management in the military (Davis, 1996). This is even more important when considering the loss of experienced personnel from the military, as well as the hardships

faced by individuals who are discharged or separated from service because of these weight standards. Indeed, the data suggests that since 1992, 24,000 soldiers in the USA have been discharged from the Army for failure to comply with weight standards (Bray et al., 2006).

As a result, the military have created various weight management programmes using a multifaceted approach which incorporates lifestyle changes in nutrition, physical activity and cognitive-behaviour modification (Dahn et al., 2011). Cognitive-behavioural modification principles have been utilised to develop military weight programmes which focus on making permanent changes to eating and behavioural patterns. Obesity and overeating are defined within a learning framework whereby overeating is an excessive response to either external or internal cues from pre-existing cognitions (Davis, 1999). It is therefore essential to recognise and re-structure these cognitions as part of improved military weight management programmes (Davis, 1999).

1. 3 Methodology

1.3.1 Aims of the current review

The main objective of this literature review is to systematically evaluate the research in order to investigate the clinical effectiveness of multifaceted cognitive-behavioural weight management programmes for the military. A systematic review[1] was considered the most appropriate strategy for

[1]Fink (2005) defines a literature review as a "systematic, explicit and reproducible method for identifying, evaluating and synthesising an existing body of completed and recorded work".

reviewing the literature as it allows for a broad consideration of the subject. Thus, the main aim of this review is to examine whether cognitive-behavioural programmes are effective in helping military personnel to lose weight. In addition, it also aims to provide direction for further research into this area, as there is a relatively small body of literature currently available. Finally, this research aims to provide a set of recommendations, drawn from the evidence, for future weight management programmes in the military.

1.4 Selection Criteria

1.4.1 Search strategy

The objective of the search strategy was to identify all of the published studies that examined the clinical effectiveness of multifaceted weight management programmes, including cognitive-behavioural components for active duty personnel in the military. In order to assess the relevant literature from the database searches, the following inclusion and exclusion criteria were applied.

1.4.2 Inclusion criteria

Studies were included within this literature review if:i) they had been published since 1990, as these were consider to be the most up to date and current programmes being offered by the military; ii) they reported on active duty personnel from the military; iii) the identified weight management programmes had a significant cognitive-behavioural element to the content; and, iv) if they had been statistically evaluated to determine the clinical effectiveness of the programme.

1.4.3 Exclusion criteria

Studies were excluded if: i) the study was in a book chapter or dissertation as these had not been peer reviewed; ii) the study utilised a population of veterans; iii) the study utilised a population of cadets or military training personnel; iv) the study utilised a case study; or, v) if the study was not written in English.

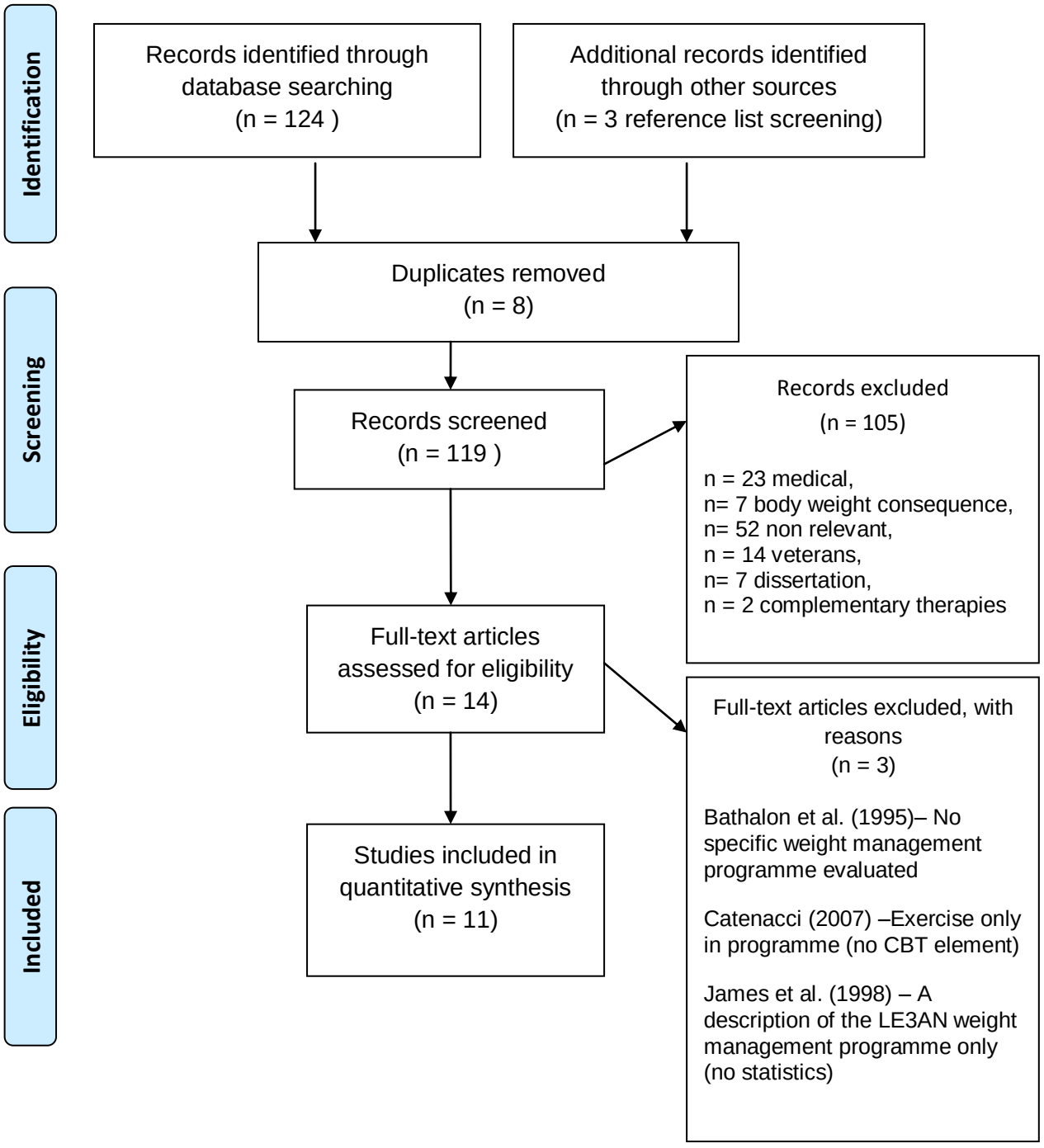
1.5 Systematic Search Result: Study Selection

The searches were completed in August 2013. One hundred and twenty-four articles were retrieved through a database search in which the following set of search terms were applied: “Military AND Weight Loss Programmes” OR “Weight Management Programmes”. The set of search terms Military AND “Cognitive-Behavioural Therapy” AND “Weight Management” produced no further results. The databases used were: “Academic Search Complete”, “PsychINFO” and “CINHAL”with full text; all of these databases were accessed through “EBSCOhost”. The Kings Military Research Centre was also examined to determine whether they had published any studies that incorporated the above search terms – but no further articles were identified. However, after reviewing the reference lists of the identified articles, a further three studies were discovered; however, one of these investigated a population of veterans and was therefore excluded.

Please refer to Figure 1 for more detail on the study selection process. This diagram was adapted from PRISMA – thePreferred Reporting Items for

Systematic Reviews and Meta-Analyses (Moher, Liberati, Tetzlaff, & Altman, 2009). This four phase flow diagram is evidence-based, and a minimum set of items considered for reporting in systematic reviews and meta-analyses.

Figure 1: Diagram of the search strategy



Adapted From: Moher et al. (2009) The PRISMA Group

1.5.1 Study quality assessment

In order to make the critique of the evidence rigorous and well-defined, a quality rating system was used to assess the methodological quality of the identified studies. Articles were not excluded on the basis of the quality score but on the ratings; these ratings contributed to the evaluation of the quality of the evidence assimilated when considering the conclusions.

1.5.2 Development of the quality assessment tool

The studies included in this review had different methodologies; some adopted randomised controlled trials whilst others used no control groups at all. Given the absence of a particular standardised quality assessment system, a novel tool was developed. This was adapted from a combination of the Down and Blacks (1998) checklist for non-randomised control studies and questions from the CONSORT 2010 statement for randomised controlled trials (Schulz, Altman, & Moher, 2010). A copy of this can be found in Appendix A.

1.5.3 Method for assessing quality

The quality assessment tool utilised in this study comprised of twenty-seven questions which assessed the different dimensions of methodological quality. Each of the eleven identified studies were assessed and scored according to these criteria; consequently, each dimension of the tool was rated as:“yes”, “no”, “partially” or “not applicable”. If rated not applicable, this item was removed from the calculation. After a total score was identified, this was then

converted to a quality assessment percentage; these can be seen in Table 1, below.

The mean percentage quality rating for all of the studies was 66.8%, with a range of 42% to 85%. The higher scores indicated the studies which had greater methodological quality. The individual ratings, using the novel checklist, for each of the identified studies can be found in Appendix B.

Table 1: Summary of main findings

Authors/Year	Quality	Sample	Description of Programme	Design	Key Findings
Trent and Stevens (1995)	77.7%	624 Navy programmers Level 1 n= 358 Level 2 n=51 Level 3 n=215.	Level 1(command-directed remedial conditioning/exercise only). Level 2 (weight management counselling and exercise). Level 3 (residential obesity treatment with stress management, self-monitoring, emotion regulation and exercise).	Intervention study – quantitative, repeated measures. A series of pre- and post-intervention weight measurements were obtained and analysed. The study utilises Feinstein's (1959) Body Fat Reduction Index that relates to the actual amount of weight or body fat lost to both the initial and the target measurement, it compensates an obese person who must lose more fat than a less obese person.	Level 3 was the most effective tier for helping participants lose body fat, whereas Level 1 was least effective. Although, the programmes succeed in helping participants lose body fat, these losses were not sufficient to meet US Navy weight standards.
Davis (1996)	70%	Active duty soldiers enrolled on the Army Weight Control Programme and attended the FLEX Programme 46 participants (34 male and 12 female).	FLEX Programme – Army Weight Control Programme (nutritional advice and exercise). In addition cognitive-behavioural modification, relapse prevention included. Phase 1 – a three-week inpatient programme. Phase 2 – outpatient follow-up.	Repeated measures design with weight, body fat percentage, cholesterol, and low density lipoprotein being dependent variables.	Results support the effectiveness of supporting personnel to lose weight in a cognitive-behavioural based weight management programme that included a three-week inpatient phase.

James (1999)	42%	112 active duty officers and enlisted personnel (71 male and 41 female).	The LE3AN acronym highlighted the primary components of: Lifestyles, Exercise and Expectations that are reasonable. The LE3AN programme offers a 2-week inpatient treatment programme and an hour of outpatient treatment for 12 months. The programme uses a variety of strategies including: self-monitoring, goal setting, problem-solving, cognitive restructuring, stress management and relapse prevention.	Participants volunteered for the LE3AN programme. Follow-up data for weight was taken at six, twelve and eighteen month periods after intervention.	Females showed a 13% weight loss at the eighteen month follow-up. Males, on the other hand, were not successful with only an 8% weight loss at the eighteen month follow-up.
Earles, Kerr and James (2007)	64%	387 active duty personnel from the US military were assigned to Armed Forces bases in Hawaii. Participants represented all branches of the military (141 female and 253 male).	A one-week day treatment programme (Phase 1) coupled with weekly outpatient follow-ups for one year(Phase 2) of the LE3AN Programme (see James, 1999).	Retrospective study of clinical effectiveness of a one-week cognitive-behavioural course followed by weekly individual follow-ups for one year.	The LE3AN Programme is based on outpatient intervention which is effective for weight loss. Of the entire sample 26.6% maintained at least 5% weight loss after one year, whilst 61.6% of the treatment completers sustained the change. The average BMI's significantly decreased for both men and women over the one-year period.
Simpson, Earles, Folen,	66%	111 African-American and European	A one-week daily treatment programme (Phase 1) coupled with 12 months of	Retrospective study of efficacy of the LE3AN Programme for active duty females.	Participation in the LE3AN Programme was associated with significant weight loss for African

Trammel and James (2004)		American active duty Army and Navy female service members enrolled on the LE3AN Programmes.	weekly outpatient follow-ups, (Phase 2) of the LE3AN Programme (see James, 1999).		American women. Furthermore, the weekly follow-up visits were correlated with greater weight loss.
Bowles (2006)	70%	93 active military personnel Army n=85, Navy n=2 Air Force n= 4 and Marine Corps n =2 (total of 55 men and 38 women).	The LIFE Programme which focuses on cognitive-behavioural principles.	Repeated measures design. Weight and BMI were measured at four points (pre-treatment, then at one month, six months and finally). Participants were also measured on the following questionnaires at the pre-and post-intervention periods: "Quality of Life" questionnaire, "The Eating Disorder Inventory", and the "Multidimensional Self-Esteem Inventory".	Over a one-year period, on average women lost 14 pounds and men lost 10 pounds. Participants lost the most weight in the first six months, but were able to maintain this over the remaining six months. Women were also able to lose more weight over the remaining six months.
Dennis, Pane, Adams and Bing Bing (1999)	66.6%	All service members classified as obese (BMI >30) from on-board aircraft carriers were included. (Male only) Treatment group n=21. The average weight before treatment was 108.1kg, standard		A two-group randomised design. The measures used pre- and post-intervention were BMI, percentage of body fat, and self report questionnaires (Profile of Mood States, Coopersmith Self-Esteem, EDI, Binge Eating Scale and Eating Self-Efficacy Scale).	Although weight loss was significant for both groups, most men did not return to the Navy standards. There was a stastical difference between treatment and control. Men lost 8.6kg (standard deviation 5kg) in contrast to the controls who lost 5kg (standard deviation 4.1kg). Moreover,ten men in the treatment group lost >9kg compared to two in the control group. The results support the ability to conduct multifaceted

		deviation=10.2. Control group n=18. The average weight before treatment was 106.7kg, standard deviation= 12.0. The two groups did not differ significantly on any baseline characteristics.			cognitive-behavioural programmes on deployed vessels.
Hunter et al. (2008)	83.3%	United States Air Force population was above their weight standards. Treatment group n=227 and control group n=222.	Internet-based weight management programmes using behavioural Internet therapy, coupled with cognitive re-structuring and motivational interviewing elements.	A two-group parallel randomised controlled design. Changes in body weight (kg and percentage change from baseline), percentage body fat and waist circumference were all measured by the study researchers,initially and at six months.	After six months, the treatment group had lost 1.3kg whilst those assigned to the usual care group gained 0.6kg.
Stewart et al. (2011)	52%	2,417 soldiers and 2,147 civilians (soldiers' family members) residing in Fort Bragg were recruited via the Internet-based on being within 5% of or	The H.E.A.L.T.H Internet programme consisted of two components: (1) an Internet-based weight management programme (Website), and (2) a promotion programme designed to promote and sustain usage of the Website. The Website remained online for thirty-	Self-selecting sample to measure the trajectory of weight across a thirty-seven month period. Measures included self-reported weights and Website utilisation statistics. Participants had to set up an account with "log on" details.	12% of the participants lost >5kg at some point during the study (thirty-seven month length), and 10% lost >5kg at some point. Website use was associated with increases in achieving this weight loss goal. The cognitive-behavioural components were found to be used on a regular basis.

		exceeding their maximum weight to height standard. Mean age was thirty-two years. The majority of soldiers had ten years experience in the military.	seven months, with the Website promotion programme ending after twenty-five months		
James, Folen and Earles (2001)	62%	48 US Navy and Army personnel were assigned to military bases in Hawaii. All participants were diagnosed as overweight (BMI of at least 27) and exceeding the military weight standard. A clinic-based group consisted of 34 patients and the interactive group included 14 participants.	A one-week, daily treatment programme (Phase 1) was coupled with weekly outpatient follow–ups for one year (Phase 2) of the LE3AN Programme (see James, 1999).	Patients unable to attend the weekly follow-ups were placed in the interactive video and Website group, they were compared to those assigned to the on-shore group who attended weekly clinic follow-ups.	No significant differences in the percentage of weight loss were found between the two groups. This suggests that cognitive-behavioural health interventions, with follow-ups through the forum of tele-health, offers significant promise for increased weight loss.

Shay, Seibert,Watts, Sbrocco and Paglaria (2009)	85%	73 participants enrolled on a weight management programme in the Navy called Shipshape.	Randomly assignment to three different conditions (paper, PDS or web-based diary). They were also classified based on whether this was their preferred method or non-preferred way of monitoring weight, percentage body fat, waist circumference and self-efficacy . These scores were measured initially, at six and twelve weeks and during an eight week intervention.	44% used their preferred method whilst 56% did not. Participants who used their preferred diary method did not adhere better to recording both their food intake and exercise. No difference was seen between the groups' weight management outcomes, but the results suggest that the individuals' diary preference affects their adherence to the diary usage. Thus, a significant amount of entries were found for those who preferred to use diaries.

1.6 Main Findings

A total of eleven studies were identified by the literature search, each of these studies were then described and reviewed in terms of their mode of programme delivery. For example, six of the identified studies focused solely on assessing the impact of multifaceted face-to-face weight management programmes. Subsequently, the review then examined the relevance of other factors affecting the effectiveness of weight management treatments, including the use of various modes of delivery that did not involve face-to-face contact with professionals, such as the forum of the Internet. Other confounding factors to treatment success, including the level of adherence to CBT homework tasks and demographic issues were then explored. In line with the aims of a systematic literature review, overarching methodological issues within the studies were firstly described before suggesting clinical/service implications for use in the military. Finally, ideas for future research that have arisen from the process of the review will be described.

1.7 Efficacy of Weight Management Programmes

1.7.1 Inpatient programmes

Three studies focused on the clinical effectiveness of the inpatient CBT weight management programmes that were offered in the military. Trent and Stevens (1995) examined the effectiveness of a three-tiered obesity treatment programme designed to assist overweight and obese personnel to meet the designated military standards. Similarly, James (1999) and Davis (1996) added

to the evidence base, for the effectiveness of multifaceted inpatient programmes, by demonstrating the success of healthy lifestyle treatment models that had a CBT emphasis. These two studies, unlike Trent and Stevens (1995), also offered longer term outpatient follow-ups (please refer to Table 1 for an enhanced description).

Trent and Stevens (1995) demonstrated that weight loss success increased for people who participated in the third level – which had the greatest cognitive component – as well as the multidimensional inpatient programme. In total, 94.2% reduced their body fat during treatment and 66.7% maintained the amount lost when measured at the twelve month stage. The success rate was lowest for those who attended only the first level, with 71.2% reducing their body fat and 56.2% maintaining this at the twelve month measurement. Trent and Stevens (1995) have therefore added to the evidence base, described in the lay literature, by demonstrating that exercise alone is infrequently effective for treating obesity (Shawet al., 2006). Additionally, Trent and Stevens (1995) demonstrated that more positive weight loss outcomes occurred in the multifaceted programme rather than the mandatory and standardised military methods (level one of the programme).

James (1999) demonstrated further success for cognitive-behavioural inpatient programmes (see Table 1 for more information). The LE3AN Programme is underpinned by the theory that an individual has the ability to control their health through their thoughts and behaviours. The programme then provides the skills and strategies to manage maladaptive eating thoughts and behaviours. This appears to be successful; to illustrate, a clinically significant difference in weight

loss between pre-intervention measurements and then at twelve and eighteen month follow-ups were observed for male and female Navy and Army personnel, whereby the men and women achieved 8% and 13% weight loss respectively. Similarly, Davis' (1996) results also indicated that inpatient weight loss programmes were effective in helping soldiers to lose weight and body fat; furthermore, the soldiers were able to maintain their weight loss at their six month follow-up appointments. It is worth noting that the six month follow-up data was low because of a high drop-out rate; many soldiers may have had difficulties in keeping their appointments due to military duties. However, it is still unclear as to whether they simply failed to keep their appointments due to increased weight.

James (1999) argues that many weight loss programmes do not adequately provide either the intensity or the length of time to address maladaptive eating habits and sedentary lifestyles that may be well stabilised in individuals who are obese or overweight. Personnel are taught in the LE3AN Programme to identify high risk emotions that may act as triggers for binge eating; concurrently, their relationship with their size and body image is also explored. An individual's relationship with food as well as their social environment, body image and emotions are also all focused on. James (1999) demonstrates that a long-term outpatient follow-up programme, which incorporates relapse prevention strategies, is more successful in providing ongoing positive weight management outcomes.

It is noted however, in the raw data measurements for participants in James (1999) study, that after the six month mark, weight loss appears to level off and

fluctuation can be observed. For example, the male Army participants' average weight rose from 217.5lbs to 220.4lbs at the twelve and eighteen month periods, respectively. Although this is still considered significantly different from the pre-intervention measurements, this could be an indication that once treatment ceased weight management may continue to be difficult for individuals. However, the sample sizes for this study were low as only thirteen Army males were studied. It is also noteworthy that this study scored the weakest on the quality framework (see Appendix B).

Two of the studies identified (James, 1999 and Davis, 1996) did not include a treatment control group in their research methodology. This makes it unclear as to how effective their inpatient programmes were when compared to the standardised weight management programmes used by the military. Furthermore, Davis (1996) and James (1999) provided no information as to whether these personnel returned to their military weight standard or whether they were removed from the weight management regime.

In summary, Trent and Stevens (1995) propose that the inpatient context and the residential milieu are effective in altering the patient's lifestyle for the duration of stay. For example dietary and exercise regimes are altered, alongside a more structured day with accessible support and encouragement. It appeared that even a two-week inpatient treatment programme was effective in producing positive weight loss outcomes (James, 1999). However, Trent and Stevens (1995) recognised that despite the apparent efficiency of their inpatient programme, at the end of the twelve months these individuals still remained

above their gender base cut-off point for acceptable body fat, according to the military standards.

These types of inpatient programmes are likely to be costly and time-consuming for the military. This research was conducted over ten years ago; since then, in 1999, the newer LE3AN Programme changed to focus on day treatment. To demonstrate this shift, the more recent literature focuses on outpatient weight management programmes in the military. Four studies were identified for outpatient treatment – these will now be examined.

1.7.2 Outpatient programmes

Earles et al. (2007) reported on an outpatient version of the LE3AN Programme that was previously reported by James (1999). One year outcome data revealed that a quarter of those who started the programme maintained at least a 5% weight loss, no significant differences of percentage weight loss were found for gender (6.56% men and 7.35% women). The authors argue that these weight losses are consistent with other behavioural obesity treatments in the civilian population (Wadden & Butryn, 2003); thus, providing support for the outpatient medium of military weight management programmes.

Bowles (2006) evaluated the “LIFE Programme”by focusing on improving service members’ well-being and the promotion of healthily lifestyle change. Group cognitive-behavioural treatment was a core element of the programme. Bowles (2006) argued that this type of modality can be empowering and offers socialisation techniques that can help with social and psychological problems that occur as a result of being overweight or obese. Overall, over a period of one

year, the LIFE programme demonstrated success in helping the fifty-three participants to achieve a significant weight loss. On average women lost fourteen pounds and men lost more than ten pounds. Most of the weight loss occurred in the first six months of the programme, but participants were able to maintain their weight loss over the remaining six months; interestingly, the women continued to lose weight over that time. This is in line with other research findings that utilised inpatient treatment programmes (James, 1999).

Bowles (2006) also comments on participants improved ability at controlling their hunger and restricting their eating, they also reported less of a preoccupation with being thin – this was measured using psychometric tests, such as the Eating Disorder Inventory. These changes, which are well documented in the literature, significantly improve the chances of maintaining healthy lifestyles and weight changes (Bowles, 2006).

Whilst these recognised positive benefits are evidenced by Earles et al. (2007) and Bowles (2006), it is still difficult to conclude that these programmes can categorically be credited for the changes in weight. The lack of a control sample makes it uncertain as to whether the weight loss could have occurred because of other changes in the individual's environment. The participants for both studies were recruited from one military medical centre, and are therefore likely to be concentrated in one location. Changes such as operational deployment, staffing and dietary arrangements, may also have occurred alongside the programmes. Furthermore, it is also unclear whether these programmes resulted in significantly more weight loss than the regular treatment programmes that the military provides, because there was no comparison group.

The effectiveness of multifaceted weight management programmes has been demonstrated in relatively accessible outpatient settings (Bowles, 2006); however, it is yet to be established as to how beneficial these are for military personnel who may not be able to attend military medical centres. Dennis et al. (1999) adopted a two-group randomised design to address a weight loss/management programme on board a Navy ship, whereby forty-seven men had failed to meet the required military weight standards. It should be noted that this study can be critiqued for its lack of generalisability to female Navy personnel. Half of the men in the study received education and support with behavioural modification, cognitive and emotional factors to influence their eating behaviours. The other half received the "usual care" from the first level of the Navy's weight programme (Trent and Stevens, 1995).

Dennis et al. (1999) clearly demonstrated the feasibility of conducting a weight management programme at sea as the weight loss outcomes were significant for both groups and they even exceeded the weight loss found in other Navy programmes (e.g. Trent and Stevens, 1995). However, most of these men still failed to meet the designated weight standards in the Navy, and it could be argued that neither the mandated or treatment programme achieved the long-term aim of supporting their personnel to maintain the Navy's weight standards. Nonetheless, the men in the treatment group lost an average of 8% body weight along with 7% body fat, and nearly 50% lost 9kg compared to the control group, who lost between 4kgand5kg with a 4% decrease in body fat. According to Gaston (1989) the findings for the treatment group are typical of naturally occurring body fluctuations during sea deployments; therefore, Dennis et al.

(1999) conclude that a cognitive-behavioural intervention could improve the Navy's current mandated programmes.

There are however significant limitations to the methodology of this study, firstly there was no blind control over the two groups, i.e. individuals understood their random assignment and the men allocated to the usual care expressed anger at the lack of support available to them. Considering the significant consequences for the men that failed to lose weight, in terms of their future career, considerable ethical dilemmas were presented by this study. Dennis et al. (1999) argue that there could have been a potential rivalry/competition between the two groups motivating the control group to lose more weight as the 9kg weight loss found in the control individuals was not typical of the Navy's remedial treatment (Dennis et al., 1999; Trent & Stevens, 1995); thus, competition may have been a motivational influence.

In summary, the positive results, found by Dennis et al. (1999), Earles et al. (2007) and Bowles (2006), support the portability of these programmes to military service personnel/settings, where it may be more convenient for people to attend outpatient appointments whilst also providing possible cost savings to the military. However, the changes identified took place in the context of a multifaceted and holistic approach, but there was no analysis into which aspects of the "LIFE" or "LE3AN" programmes accounted for the behavioural changes. Thus, further research could be conducted to investigate which aspects of the programmes accounted for the changes. Findings from this would most likely provide information that would result in more sharply focused interventions,

thereby increasing efficiency and convenience (Bowles, 2006) and providing further cost savings.

1.7.3 The use of the Internet/interactive forums in military weight management programmes

Given the worldwide deployment of military personnel, it is important to consider the flexible ways in which treatment can be offered. James et al. (2001) conducted a study which examined the effectiveness of providing follow-up programmes after an individual had initially completed the LE3AN Programme (see Earles et al. 2007) using interactive methods/design.. Two studies focused on implementing a weight management programme across the Internet as a platform (Hunter et al., 2008; Stewart et al., 2011). It is also noteworthy that the Hunter et al. (2008) study scored high on the methodological quality framework.

Previous research has identified the Internet as having a broader and more accessible approach to weight management; furthermore, individuals have even indicated a preference for the Internet over face-to-face professional contact (Winett, Tate, Anderson, Wojcik, & Winett, 2005). Personnel may therefore benefit from utilising a "treatment" form whereby they do not have to attend appointments at a military medical centre. The lay literature has provided some promising results for the effectiveness of Internet weight management programmes which utilise tailored interventions, including the use of online discussion forums and individual monitoring feedback (Tate, 2001).

Hunter et al. (2008) and Stewart et al. (2011) evaluated the effectiveness of Internet-based cognitive-behavioural programmes for weight management in

military settings. These programmes included the use of: online monitoring, goal-setting and tutorials that focused on common strategies associated with behavioural weight loss, including behaviour modification and stress management techniques (Hunter et al., 2008).

Both studies utilised participants who were within five pounds or above their maximum allowable military weight standard. A robust methodology of a two-group randomised control was used by Hunter et al. (2008). One group received "usual care", which included mainly physical activity three-times a week with some dietary advice and the other received "usual care" and the Internet programme. However, one of the limitations in this design was the lack of objective measurement of physical activity; it was not clear what constituted "physical activity" – this could have involved a brisk walk or a fast run. Stewart et al. (2011) provided no control group and relied solely on self-reported information concerning body weight and size.

With regard to the results, after six months, Hunter et al. (2008) demonstrated that the participants using the Internet programmes lost 1.3kg with significant changes in BMI and body fat, whilst those assigned to the usual care group gained 0.6kg. Whilst these weight loss figures can be classified as medically significant, they are not as significant as some other Internet-based weight management studies for non-military populations (Tate, 2001). This could be linked to the lower average starting weight, as compared to other studies, and the fact that participants were recruited primarily to prevent weight gain.

Stewart et al. (2011) reported that 12% of the participants lost more than 5% of their weight at some point in the study; thus suggesting that this programme was

effective in promoting weight loss. However, this is less than the reported figures for the Air Force personnel; to illustrate, Hunter et al. (2008) demonstrated that 22.6% lost at least 5% of their baseline weight. Stewart et al. (2011) had no human or individualised contact with their participants, compared to the telephone calls and online guidance provided by Hunter et al. (2008); Hunter et al. (2008) suggest that perhaps this is what accounts for the difference.

The participants who reported accessing their Website more regularly, and who participated in thorough monitoring, had better outcomes in both of the studies. Hunter et al. (2008) offered motivational telephone calls throughout the course of their programmes, this increased use of the Internet. However, this was not delivered to all "treated" participants, and it was not recorded whether the participants who received the phone calls in fact increased their use of the Internet programme. It is therefore not clear as to the effect of this intervention in promoting more use of the programme. In comparison, the H.E.A.L.T.H Website used by Stewart et al. (2011) automatically collected data to evaluate patterns of usage in response to promotional events. Stewart et al. (2011) discovered that after the removal of the promotion regime, the number of repeated logins significantly decreased, along with significant decreases in enrolment. Stewart et al. (2011) concluded that promotion programmes are necessary to promote enrolment and utilisation over longer periods of time.

Despite Hunter et al. (2008) using a large sample size (446 participants), all of the participants were from the American Air Force; thus, these findings are not generalisable to the rest of the military services. In addition, Stewart et al. (2011) obtained results over a much larger timeframe (three years), which does not

necessarily demonstrate the effectiveness of the programme over time. To illustrate, as it was not a closed/fixed group schedule, some people may have joined relatively late in the programme; it is therefore less clear as to the long-term maintenance benefits of these Internet-based weight management programmes.

Many personnel were unable to participate in onsite weekly follow-ups due to deployment – this represents an ongoing logistical concern for the military. The evidence suggests that successful treatment of obesity requires frequent follow-ups and long-term treatment in order to maintain losses (Perri, Nezu, Patti, & McCann, 1989). James et al. (2001) examined the effectiveness of providing follow-up programmes after the initial completion of the LE3AN Programme (see Earles et al., 2007) via interactive mediums. Promising results were identified in regards to weight loss. Interestingly, there were no significant differences in outcomes between the individuals attending onsite follow-up sessions and those receiving follow-ups through interactive applications.

Although the success of the James et al. (2001) study provides promising results for the use of interactive measures for individualised long-term follow-ups, these findings resulted from a feasibility project that only focused on a small sample of forty-eight Navy and Army personnel from the USA. It is questionable whether these findings would be generalisable to military organisations from other counties where interactive measures may be less accessible, or for those personnel members on active operational duty/theatre. Follow-up weight measurements were only recorded at the three-month mark; thus, in order to

reach firmer conclusions, further investigation over a whole year of quarterly follow-ups would be needed.

1.7.4 Summary

Despite their limitations, Hunter et al. (2008), Stewart et al. (2011) and James et al. (2001) all claim that they have demonstrated promising results for the use of the Internet and interactive mediums in achieving widespread delivery and dissemination of evidence-based weight management programmes. Moreover, Hunter et al. (2008) successfully demonstrated the effectiveness of an Internet-based cognitive-behavioural military weight management programme over standardised military care.

1.8 Other Confounding Variables to Treatment Success

The remaining identified studies focused their research efforts on examining other confounding variables to the treatment success of military weight management programmes.

1.8.1 Adherence in military weight management programmes

The monitoring of food, exercise and emotions are essential elements of cognitive-behavioural therapy within a weight management context (Baker & Kirschenbaum, 1993). Research suggests that treatment outcomes may be improved if individuals receive greater control over their treatment choice (Legg-England & Evans, 1992). Shay et al. (2009) argued that greater autonomy of the monitoring methods could improve the outcomes. The study reported findings on

preference of food monitoring/diary tools in relation to adherence, self-efficacy and changes in body composition for Navy members who completed a cognitive-behavioural weight management programme. Shay et al. (2009) found no significant difference in weight loss outcomes, self-efficacy or eating patterns between the participants who completed their preferred diary method to monitor their energy/dietary intake to those using their non-preferred method.

Despite the lack of statistical difference in adherence between the individuals who were given their preferred monitoring tool and those who were not, a greater number of entries were discovered for those working with their preferred method of monitoring. A relationship was also found between weight loss and the number of days in which food intake was recorded, i.e. better monitoring increased weight loss. This is consistent with the literature that acknowledges self-monitoring as a core intervention in CBT (Shay et al., 2009).

There are a number of limitations to this study. Firstly, most of the participants had an urgent need to lose weight because of the bi-annual military weigh-ins; thus, irrespective of the chosen method of monitoring, all of the participants lost weight whilst attending Shipshape, making it less comparable to a voluntary civilian population. Secondly, no data was collected to ascertain the sustainability of this weight loss. Nonetheless, there is emergent evidence for the benefits of tailoring interventions to suit a person's preference (Shay et al., 2009).

1.8.2 Demographic factors

One study focused on the effectiveness of a weight management programme for other ethnicities in military services, in addition to white American; this considers the fact that the military is comprised of a diverse population. Simpson et al. (2004) suggest that ethnic minority women, in general, experience high rates of obesity; furthermore, African American females have poorer weight loss outcomes. This retrospective study focused on the effectiveness of the LE3AN Programme (see James et al., 1999) for active duty females of European American and African American origin. The programmes used the guidelines suggested by Kumanyika and Morssink (1997) to adapt weight loss programmes to work more effectively with diverse populations; this included the avoidance of negative stereotypes, the integration of familiar resources and improving accessibility.

The results demonstrated that participation in the programme generated significant weight loss for both African American and European American active duty females. A mean weight loss of 12.12lbs was reported, falling within the 5-10% weight standard suggested by the literature to assist individuals with lowering health risks (Simpson et al., 2004). In addition, there were no significant weight loss differences between the demographic groups.

The dropout rate for the African American group was high; to illustrate, fifty-six participants enrolled but only twenty-six remained. Consequently, unequal sample size groups were analysed post-treatment, and the reasons for dropout were unknown. The attrition rate within the ethnic groups needs to be explored further, as it may be questionable as to whether this programme met their weight

loss needs. All of the other studies identified in this review reported no significant differences in relation to demographic factors and weight loss outcomes (Davis, 1996; Bowles, 2006; Dennis et al., 1999).

The study by Simpson et al. (2004) had no control group which prevents robust causal inferences. The sample was also highly specific as only women were included in the study; thus, it needs to be replicated with men. It is important to note that there are proven variations in weight loss outcomes for the different genders of military personnel. For example, Bowles (2006) demonstrated that most weight loss in the LIFE Programme occurred at the six month mark for men, whereas the women continued to lose weight throughout the one year programme. Bowles (2006) argues this may be due to women being more practiced with food preparation and meal portioning, compared to men. This is an assumption made by the author and therefore needs further empirical investigation.

1.9 Overall Summary

This review has highlighted that there is some evidence for the clinical effectiveness of multifaceted cognitive-behavioural programmes for the military (Bowles, 2006; Davis, 1996; Dennis et al., 1999; Earles et al., 2007). Success has been demonstrated in both inpatient and outpatient forums, with outpatient programmes proving just as successful at supporting personnel to lose weight as inpatient programmes (Earles et al., 2007). Furthermore, Hunter et al. (2008), Stewart et al. (2011) and James et al. (2001) claim they have demonstrated promising results for the use of the Internet and interactive adaptations for

achieving widespread delivery and dissemination of evidence-based weight management programmes in the military. There is also emerging evidence to suggest that the “LE3AN Programme” is suitable for military personnel from diverse ethnicities (Simpson et al., 2004).

Despite the demonstration of clinical effectiveness for CBT weight management programmes, the studies have shown that some military personnel still fail to meet their mandatory military weight standards even after completion of a weight management programme (Trent & Stevens, 1995; Dennis et al., 1999). Long-term reviewing and monitoring of the maintenance effects of such programmes is therefore needed to fully map the trajectory of weight management for military individuals. These findings also need to be considered in the context of a range of methodological factors**.**

1.10 Methodological Considerations

It has been well documented throughout the course of this review that all of the studies contained some methodological limitations. One of the main limitations across the range of studies is concerned with the lack of comparable evidence. Only three of the eleven studies utilised a comparison group to the mandatory military programme. This therefore limits and restricts the conclusions which suggest that multifaceted weight management programmes are more successful at supporting weight loss than the current mandatory programmes which focus solely on exercise and dietary advice.

The body of literature also lacks generalisability in terms of worldwide military services, as the studies generally focused on personnel who served with the

United States Armed Forces; these findings are therefore less likely to be comparable to smaller military forces from other countries. Studies were also conducted in one main geographical location which meant that other changes in context could have contributed to outcomes.

In addition, inconsistency in the measures used to ascertain weight loss were also acknowledged. Only one study (Trent and Stevens, 1995) utilised the Weight Reduction Index which takes into account biases for people who have more weight to lose, such as those diagnosed as obese. However, other studies included more comprehensive sets of outcome measures, such as taking body fat measurements for the pre- and post-treatment periods (Davis, 1996; Dennis et al., 1999; Hunter et al., 2008). In general, the reviewed studies focused on pre- and post-programme weight gain, and it is therefore unclear whether these results could have been biased by the larger number of obese people in the sample. Indeed, in the study by Bowles (2006), the average starting weight was 216.34lbs for men with a standard deviation of 25.97 – this demonstrates a large variability.

The studies reviewed also lacked longitudinal follow-ups; all of the identified studies stopped recording data after the one year mark, and some only ascertained weight maintenance to the six month mark (Davis, 1996). There is no evidence to ascertain whether the individuals who lost weight returned to normal operations or whether they were removed from military weight monitoring. This information could have contributed to establishing whether multifaceted programmes, which adopt cognitive-behavioural components, are worth investment for the military.

1.11 Clinical and Service Implications for the Military

The current weight management programmes offered in the military appear to be sporadic; furthermore, the research generally concentrated on individuals serving within the United States Armed Forces. The military may want to consider implementing a more unified approach to weight loss by incorporating a multifaceted cognitive-behavioural featured programme into their existing “usual care” approach, as these types of multifaceted programmes have been shown to be more successful in supporting personnel to lose more weight than the mandatory methods which mainly consist of exercise (Dennis et al., 1999).

There are also additional clinical implications for the military, in terms of their need to adapt weight management programmes to meet the diverse needs of their personnel. There is evidence to suggest that interactive methods, such as web-based design, the Internet and tele-health applications, are effective in providing treatment follow-ups and supporting positive weight loss outcomes (Hunter et al., 2008; James et al., 2001). Furthermore, ethnic minorities and culturally different groups within the military can also benefit from such programmes (Simpson et al., 2001); consequently, this may help with wider application.

It has been demonstrated that individualised feedback, with regards to monitoring and support, is more successful in achieving better weight loss outcomes than generic feedback (Hunter et al., 2008). It may therefore be necessary to review the current type of individual support provided within the

mandatory programmes in order to increase the effectiveness of these programmes.

1.12 Future Research

There are various areas in which future research could be directed; for example, developing a greater understanding of the relapses associated with weight loss programmes as well as the elements which entice individuals to either stay or leave a programme. In doing this, assessing the impact of motivation and pressure to attend military programmes may be of relevance. Most of the studies concluded that the military are a highly specific population in that they do not voluntarily attend weight management programmes.

Many of the programmes detailed by the studies identified in this review discussed the core ethos of their treatment as one of healthy living rather than solely weight loss. Further research is needed into how the dimensions of wellness and healthy living relate to motivational factors for weight loss. Furthermore, exploration of how these can be supported and encouraged in the military is needed.

Further research is also needed into demographic factors, such as gender and ethnicity, in order to determine whether they influence the effectiveness of multifaceted weight management programmes. Some of the identified studies focused solely on men (Dennis et al., 1999), they therefore require replication to ascertain the feasibility of such programmes in wider deployment settings. Simpson et al. (2004) also used only a small sample size, with a range of ethnic

groups in one area/service of the military, this warrants further follow-up and investigation across wider ethnic groups.

The impact of group settings to a programme's success also needs to be further understood. Bowles (2006) suggested that feedback from the other personnel completing the "LIFE Programme" was the second most important motivator to reinforce weight loss. Furthermore, social support appears to correlate to success in some civilian weight studies by helping to maintain weight loss (Kopelman, 2007). Further investigation into military social climates may help to identify and promote weight loss whilst also decreasing dropout rates.

1.13 Conclusions

This review has highlighted evidence of the clinical effectiveness of multifaceted cognitive-behavioural programmes for the military (Bowles, 2006; Davis, 1996; Dennis et al., 1999; Earles et al., 2007). Furthermore, studies which adopted randomised control designs highlighted more positive outcomes in regards to weight loss than the standard and universal usual care procedure adopted in the military in the USA (Dennis et al., 1999; Hunter et al., 2008). This review highlights that the incorporation of a multifaceted programme, that includes individualised feedback and monitoring (Hunter et al., 2008), within the standardised weight management programmes may be useful in helping personnel lose more weight and improve their quality of life (Bowles, 2006).

In line with the second aim of this paper, the reviewed evidence suggests that further research should be completed in order to ascertain longer term weight management outcomes. In particular, further longitudinal evidence is needed to

determine whether individuals actually met the military weight standards. The evidence reviewed is restricted to personnel members of the United States Armed Forces, and most of which included relatively small sample sizes; in addition, high relapse rates occurred even in these small sample sizes. Further research should not only concentrate on the effectiveness of military weight management programmes in other countries, but further understanding is needed as to the elements which motivate personnel members to stay in a weight management programme. Finally, individual weight loss did occur in the context of a multifaceted and holistic weight management programme; however, further analysis is needed to determine which aspects/components of the programmes actually accounted for the desired behavioural changes.

1.14 References

Ahern, A. l., Olson, A. D., Aston, L. M., & Jebb, J. A. (2011). Weight watchers on prescription: An observational study on weight change among adults referred to weight watchers by the NHS. *BMC Public Health, 1,* 434-445. doi:10.1186/1471-2458-11-434

Baker, R. C., & Kirschenbaum, D. S. (1993). Self-monitoring may be necessary for successful weight control. *Behaviour Therapy, 24,* 377-394.

Bray, R. M., Laurel, L. H., Rae Olmstead, K. L., Witt, M., Brown, J. M., Pemberton, M. R., … Hayden, D. (2006). *2005 Department of Defense Survey of Health Related Behaviours among Active Duty Military Personnel. Retrieved from http://www.ha.osd.mil/special_reports/2005_Health_ Behaviors_Survey 1-*07.pdf.

Bowles, S. (2006). The LIFE program: A wellness approach to weight loss. *Military Medicine, 171,* 1089-1100.

Carlton, J. R., Manos. G. H., Van Slyke, J. A. (2005). Anxiety and abnormal eating behaviours associated with cyclical readiness testing in a naval hospital's active duty population. *Military Medicine, 170* (8), 663-670.

Dahn, J. R., Fitzpatrik, S. L., Llabre, M. M., Apterbach, G. S., Helms, R. L., Cugnetto, M. L., Klaus, J., Florez, H., & Lawler, T. (2011). Weight management for veterans examining change in weight before and after move. *Obesity, 19 (5),* 977-981. doi: 10.1038/oby.2010.273

Dansinger, M. L.,Gleason, J. A., Griffith, J, L., Selker, H. P., &Schaefer E. J. (2005). Comparisons of the Atkins, Orish, Weight Watchers and zone diets for weightloss and heart disease reduction: A randomised trial. *Journal of American Medical Association, 293 (1),* 43-53.

Dansinger, M. L., Tatsioni, A., Wong, J. B., Chung, M., & Balk, E. M. (2007). Meta-analysis: the effect of dietary counselling for weight loss. *Annals of Internal Medicine*, *147*(1),41-50.

Davis, M. (1996). A comprehensive weight loss programme for soldiers. *Military Medicine, 161*, 614-621.

Department of Health. (2013). *Reducing obesity and improving diet.* Retrieved from https://www.gov.uk/government/policies/reducing-obesity-and-improving diet.

Dennis, K. E., Pane, K. W., Adams, B. K., & Bing Bing, Qi. (1999). Impact of a shipboard weight control programme. *Obesity Research, 7* (19), 60-67.

Downs, S. H., & Black, N. (1998).The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiological Community Health, 52* (6), 377-384.

Earles, J. E., Kerr, B., & James, L. (2007). Clinical effectiveness of the LE3AN program: A military healthy lifestyle program. *Journal of Clinical Psychology Medical Settings, 14*, 51-57. doi: 10.1007/s10880-007-9052-0

Fear, N. T., Sundin, J., & Rona, R. (2011). Obesity in the United Kingdom's Armed Forces: Prevalence Based on Measured and Self-Reported Data. *Military Medicine, 176* (1), 44-49.

Feinstein, A. R. (1959). The measurement of success in weight reduction. *Journal of Chronic Diseases, 10* (5), 439-456.

Fink, A. G. (2005). *Conducting Research Literature Reviews: The Internet to the Paperback*. Thousand Oaks, California: Sage Publications.

Forsight (2007, October 7). Tackling Obesity: Future Choices - Foresight Report 2007. Retrieved February 13, 2014, from http://www.erpho.org.uk/viewResource.

Franz. M. J., VanWormer, J, J., Crain, A. L., Boucher, J. L., Histon, T., Caplan, W., Bowman, J. D., & Pronk, N. P. (2007). Weight loss outcomes: A systematic review and meta-analysis of weight loss clinical trials with a minimum 1-year follow-up. *Journal of the American Dietetic Association*, *107* (10),1755-1767.

Friedl. K. (2012). Body composition and military performance – many things to many people. *Journal of Strength and Conditioning Research, 26* (14), 87-100.

Gaston, B. M. (1989). Weight change underway in port in the American Navy. *International Journal of Obesity, 13* (6), 84-92.

Goodpaster, B. H. (2010). Effects of diet and physical activity interventions on weightloss and cardio metabolic risk factors in severely obese adults. *Journal American Medical Association, 304* (16), 1795-1802.

Hedley, A. A., Ogden, C. L., Johnson, C. L., Carroll, M. D., Curtin, L. K., & Flegal, K. M. (2004). Prevalence of overweight and obesity among US children, adolescents and adults, 1999-2002. *Journal of American Medical Association, 291* (23), 2847-2850. doi: 10.1001/ jama.291.23.2847

Hunter, C. M., Peterson, A. L., Alvarez, L. M., Poston, W. C., Brundige. A. R., Haddock, C. K., … Foreyt, J. P. (2008). Weight management using the Internet a randomised controlled trial. *American Journal of Preventative Medicine, 34* (2), 119-147. doi: 10.1016/j.amepre.2007.09.026

James, L. C. (1999). The tripler LE3AN program: A two year follow-up project. *Military Medicine, 164,* 389-395.

James, L. C., Folen, R. A., & Earles. J. (2001). Behavioural telehealth applications in the treatment of obese soldiers: A feasibility project and a report on preliminary findings. *Military Psychology, 13* (3), 177-186.

Kazdin, A. E. (1978). *History of behaviour modification: Experimental Foundations of Contemporary Research.* Baltimore: University Park Press.

Kopelman, P. (2007). Health risks associated with overweight and obesity. *Obesity Reviews, 8,* 13-17. Retrieved from http://0-onlinelibrary.wiley.com.

Kumanyika, S. K., & Morssink, C. B. (1997). Cultural appropriateness of weight management programs. In S. Dalton (Ed.), *Overweight and Weight Management* (pp. 69-106). Gaithesburg, MD: Aspen.

Legg-England. S., & Evans. J. (1992) Patients' choices and perceptions after an invitation to participate in treatment decisions. *Social Science & Medicine, 34* (11), 1217-1225.

McDonald, P. (2009). A diet-free approach to weight loss. *Practice Nurse, 37*, 32-35.

McNulty, P. A. (1997). Prevalence and contributing factors of eating disorder behaviours in active duty Navy men. *Military Medicine, 162,* 753-758.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G. (2009). Preferred reporting items for systematic review and meta-analysis: The PRISMA statement. *PLoS Medicine, 6* (6): e1000097. The PRISMA group.

National Institute for Health and Care Excellence. (2006). *Obesity guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (NCG43 Obesity: NICE guideline)*. Retrieved from http://guidance.nice.org.uk/ CG43/NICEGuidance.

Nolte, R., Franckowiak, S. C., Crespo, C., & Andersen, R. (2002). US military weight standards, the percentage of US adults that meet the current standards. *The American Journal of Medicine,113* (6), 486-490.

Ogden, C. L., Caroll, M. D., Curtin, R. L., McDowell, M. A., Tabak, C. Y., & Flegal, K. M. (2006). Prevalence of overweight and obesity in the US, 1999-2004. J*ournal of American Medical Association, 295* (13), 1549-1555.

Peterson, A. L., Talcott. G. W., Kelleher. W. J., & Smith. J. D. (1995). Bulimic weight loss behaviours in military versus civilian weight management programmes. *Military Medicine, 160,* 616-620.

Perri, M. G.,Nezu, A. M., Patti, E. T., & McCann, K. L. (1989). Effect of length of treatment on weight loss. *Journal of Consulting and Clinical Psychology, 57* (3), 450-452.

Polivy, J. & Herman, C. P. (2002). Causes of eating disorders. *Annual Review of Psychology, 53*, 187-213.

Prentice, A. M., & Jebb, S. A. (2001). Beyond body mass index. *Obesity Reviews, 2* (3),141-148.

Schulz, K. F., Altman, D. G., & Moher, D. (2010). CONSORT 2010 Statement: Updated guidelines for reporting parallel group randomised trials. *Annals of Internal Medicine, 152* (11), 726-732.

Shaw, K., O'Rourke, P., Del Mar, C., & Kenardy, J. (2006). *Psychological interventions for overweight or obesity (review)*. John Wiley & Sons. Retrieved from http://www.thecochranelibrary.com.

Shay, L. E., Seibert, D., Watts, D., Sbrocco, T., & Paglira, C. (2009). Adherence and weight loss outcomes associated with food exercise preference in a military weight management programme. *Eating Behaviours, 10* (4), 220-227.

Simpson, M., Earles, J., Folen, J., Trammel, R., & James, L. (2004). The Tripler Army Medical Centre's LE3AN program: A six-month retrospective analysis of program effectiveness for African-American and European American females. *Journal National Medical Association, 96* (10), 1332-1338.

Stewart, T., Hongmei, H., Allen, R., Bathalon, G., Ryan, D., Newton, R. L., & Willamson, D. A. (2011). H.E.A.L.T.H. Efficacy of an Internet population based behavioural weight management programme for the US Army. *Journal of Diabetes Science and Technology, 5* (1), 178-187.

Tate, D. F., Wing, R. R., & Winett, R. A. (2001) Using Internet technology to deliver a behavioural weight loss program. *American Medical Association*, *285*, 1172–1177.

Trent, L., & Stevens, L. (1995). Survey of the Navy's three tiered obesity treatment programmes. *Military Medicine, 160,* 326-330.

National Institute for Health and Clinical Excellence (2006). *Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children.* London: NIHCE. Retrieved from http://www.nice.org.uk.

US Department of the Army. (1986). *The Army Weight Control Program* (Army Regulation 600-9). Washington, DC: Government Printing Office.

Wadden, T. A., & Butryn, M. L. (2003). Behavioural treatment for obesity. *Endocrinology and Metabolism Clinics of North America, 32*, 981-1003.

Winett, R. A., Tate, D. F., Anderson, E. S., Wojcik, J. R., & Winett, S. G. (2005). Long-term weight gain prevention: A theoretically based Internet approach.*Preventative Medicine*, *41,*629-641.

World Health Organisation. (2003). *Obesity and Overweight*. Retrieved from http://www.who.int/mediacentre/factsheets/fs311/en/index.html.

CHAPTER TWO:

EMPIRICAL PAPER

UNDERSTANDING THE LIVED EXPERIENCES OF UK ARMY VETERANS' TRANSITION FROM MILITARY TO CIVILIAN LIFE: A PHENOMENOLOGICAL STUDY

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2.0 Abstract

This study adopted a qualitative phenomenological approach to explore the lived experiences of UK Army veterans' transition from active military duty to civilian life. Eight male veterans took part in a semi-structured interview, the data was then analysed using Interpretive Phenomenological Analysis (IPA) techniques. Four super-ordinate themes emerged from the analysis of the interviews. Firstly, "Consequences of leaving the Army: I'm on my own now" comprised of sub-ordinate themes that reflected the veterans' experiences of feeling isolated and abandoned since leaving the Army, coupled with negative emotional consequences. The super-ordinate theme of "Them and Us" refers to the perceived differences in mentality between veterans and civilians. The third super-ordinate theme, "Surviving civilian life" was grounded in the veterans' experiences of coping/managing their transition out of the Army. This theme reflects maladaptive strategies, including the use of alcohol, but it also incorporates the role of resilience and support from specific veteran support services. The final super-ordinate theme was "Constructing a new identity"which referred to the veterans' experiences of attempting to merge a familiar military identity with new roles within a civilian, working and home, environment. Methodological limitations and clinical implications were also discussed.

2.1 Introduction

The research by Iversen, Nikolaou et al. (2005) indicates that many military serving personnel have successful reintegration experiences and only a minority fare badly after service. However, transition into civilian life is not without its challenges, and the impact of re-entry permeates into many aspects of a service member's life (Beder, Coe & Sommer, 2011). There continues to be a limited amount of research exploring these military transitions. Most of the literature focuses on specific groups of military personnel leaving the forces, such as those with an acquired disability obtained from operational tour or mental health problems such as Post-Traumatic Stress Disorder (PTSD); in general these studies are centred on samples drawn from personnel who have seen active service within the United States of America's Armed Forces. Under recent changes implemented in the United Kingdom (UK),by the Ministry of Defence (MoD), there will be substantial reductions in the regular Army as a result of the linked redundancies initiative (The Strategic Defence and Security Review, 2010). This makes the rationale for further research into the effects of personnel leaving the Armed Forces in the UK more important than ever; thus, information in this area would help to create appropriate and tailored support services.

2.1.1 Family integration difficulties

When an individual moves from active military duty to civilian life they are often not alone as they regularly return with families and partners. Integration appears to be more difficult when there are pre-existing couple or family vulnerabilities,

alongside service member injury and/or mental health problems (Peebels-Kleiger & Kleiger, 1994).

Several studies have attempted to explain the reasons for difficulties in family integration, during these transitions. Drumment, Coleman and Cable (2003) suggest the families or partners of veterans may experience a loss of autonomy, previously they would have run the household in the veteran's absence; thus, their return results in an adjustment of these roles and functioning actions. Peppels-Kleiger and Kleiger (1994) suggest that veterans have been trained in a specific manner for a specific purpose; this may have been very adaptive for them in the military, but it may prove to be problematic when at home.

2.1.2 Mental health problems in service leavers

There is a growing body of literature that reports mental health problems in veterans, including PTSD, depression and generalised anxiety. Hogue, Auchterlonie and Milliken (2006) found that 16% to 19% of returning Operation Iraqi Freedom[2] military personnel and 11% of returning Operation Enduring Freedom[3] met screening criteria for at least one of these problems. Iversen, Dyson et al. (2005) suggest that those most vulnerable to mental health problems were demographically single and from enlisted ranks as opposed to commissioned ranks. Furthermore, they described a gap between those reporting mental health problems and those seeking treatment.

[2] This is the US Department of Defence's designation for military deployments within Iraq.

[3] This is the US Department of Defence's designation for military deployments within Afghanistan.

Various factors appear to contribute to veterans not seeking help, in particular centring on the concept of stigma and the adoption of avoidance strategies, including: using alcohol as a primary coping mechanism (Snell & Tusaie, 2008). Research has also demonstrated that a sense of resilience and stoicism may also explain why ex-service personnel fail to seek help. This has been amplified further by the emphasis in military culture on masculinity, courage and resilience (Iversen, Dyson et al., 2005). Mansfield, Bender, Hourani and Larson (2011) suggest that personnel in "leaving or transitional" states are a critical target population for mental health screening, surveillance and intervention, as it is apparent that some ex-personnel experience a delayed onset of mental health difficulties.

Walker (2010) reports on the various assistance options available to military personnel by commenting on the Armed Forces resettlement package which intends to help with the transition from military to civilian life; this package consists of a cash payment, advice on jobs and training whilst also placing an emphasis on practical rather than emotional support. Upon leaving the Armed Forces in the UK, responsibility for medical care is passed to the National Health Service (NHS); Walker (2010) describes this route as being inappropriate for the specific needs of the leaver as this compares unfavourably to the provisions available in the USA. However, a few other initiatives are implemented to improve the treatment of veterans in the UK, such as the "Combat Stress" organisation– a charity working with veterans of the British Armed Forces who require support for mental health problems.

2.1.3 Transition experience

Staden (2007) suggests that there are clearly differences in the outcome of transition experiences for personnel moving from military to civilian life; as such, some have successful transitions whilst others experience poor transitions. Poorer transitions have been associated with access to welfare and the UK military's preference of informal rather than formal services. Those most at risk of poorer transitions, according to Staden (2007), include those who grew up in care, low income homes or in families with conflict.

Further studies have explored veterans' transitions and readjustments out of the military. Beder et al. (2011) utilised a sample of US Army veterans to identify potential trigger areas of transition experiences in order to help mental health practitioners with subsequent interventions. The results demonstrated that women veterans had specific transitional difficulties in terms of familial integration, and older veterans were more likely to experience difficulties in personal, family and work integrations. Contrary to some of the previous literature on family integration, this study also found a buffering effect of reintegration for veterans who were in a permanent relationship and had dependent children. However, there were more problems experienced in integration for those with direct combat experience and for those who had been wounded.

In terms of clinical implications, Beder et al. (2011) concluded that clinicians need to explore combat exposure, length of deployment and war-related experiences to assess the importance of these factors in the choice of treatment approaches. The researchers also highlight the need for study replication with

veterans from other serving countries, as these veterans may return to different economic, social, cultural and healthcare systems.

One study explored the challenges facing individuals of post-active duty (Demers, 2011). This study utilised a qualitative thematic analysis methodology in the form of focus groups with forty-five participants. The aim of the study was to describe the real life/lived experiences of returning USA veterans' in terms of community reintegration. Emerging themes from the participants' responses identified: difficulties losing the military identity and tension between civilians and returning personnel who felt frustration over the lack of knowledge of military life in civilian environments. Demers (2011) described the perceived civilian and military cultural gap as an explanation for veterans' experiences of feeling misunderstood and disrespected, leading to their isolation.

Brewin (2010) investigated a sample of UK veterans, this study was specific to war pensioners and those diagnosed with PTSD; it is therefore not representative of all veterans. Brewin (2010) reported several key themes associated with veteran transition experiences, some of which were conferred by Demers' (2011) study which considered: feelings of bewilderment, isolation, disillusionment and a lack of appreciation by civilians.

Local NHS service guidelines in the UK have begun identifying the unmet healthcare needs of the veteran population. NHS Bedfordshire, in 2012, conducted a Veterans Mental Health Needs Assessment; they later issued key service implications that were based on feedback from the veterans. Interestingly, the assessment highlighted that healthcare facilities, such as General Practices (GPs), whom veterans first come into contact with, should

have a better understanding of veterans' specific mental health needs as well as a deeper understanding of the experiences of being a veteran in order to support successful engagement with services for veterans.

2.1.4 Rationale for the present study

Quantitative research in the military has focused on factors that increase the risk of further difficulties and problems in transition, including age, gender and mental health problems (Beder et al., 2011). It is important to note that little is known about veteran experiences of leaving the Army or their perceptions or descriptions of the process of reintegrating into society. Demers (2011) provided a wealth of information and emergent themes about reintegration, from the USA. Thus, future research should be conducted with personnel leaving the military in other countries, in order to consider the different discharge procedures as well as the different social and healthcare contexts. Furthermore, there is a gap in the literature concerning the experiences and perceptions of support that service leavers receive whilst in transition.

A phenomenological interpretative approach is deemed most appropriate for capturing the real life experiences of personnel in transition. This is based on the assumption that when people experience a major life event, including leaving the Army, the multidimensional aspects of their response: cognitive, affective and existential, come to the fore. A holistic phenomenological approach is particularly appropriate at capturing such information (Smith, Flowers, & Larkin, 1999). By using this methodology the current study will add to the literature base by providing rich and detailed information about the process as well as unique

experiences of individuals leaving the Army. It is hoped that emergent themes from the reported experiences could then be incorporated into local policies and training schemes to help increase awareness for future service leavers.

2.1.5 Aim of the study

The overall objective of this study is to explore and examine the real life experiences of UK Army veterans, in their transition from military to civilian life. A group of Army veterans who attended a specific veteran support agency were included in the study. The research will also aim to provide in-depth information by addressing the following “secondary” research questions – these can only be answered at the more interpretative stage and are therefore grounded in the phenomenological accounts (Smith, Flowers & Larkin, 2009):

1) How do veterans perceive their experiences of support services in the UK?

2) How do veterans describe and perceive how they cope with their transition experiences?

2.2 Method

2.2.1 Ethical approval

Ethical approval was granted from Coventry University (Appendix E). In addition, informed consent was obtained from all participants; it was also made clear that they could withdraw from the research at any time without explanation. A participant could potentially become distressed at any point during the interview;

as a result, the researcher would regularly offer to stop the interview, give support and signpost the veteran to any relevant agencies.

2.2.2 Design

A qualitative methodology was deemed appropriate in order to address the "lived experiences" and personal participant accounts of transition from military to civilian life – this approach would allow for in-depth views and experiences to be expressed. The study utilised semi-structured interviews, and according to Smith and Eatough (2007), this method is a widely used means of allowing participants the opportunity to provide open and thorough accounts of their own stories.

2.2.3 Participants and recruitment

A small homogenous sample of eight veterans, attending the same veterans support service, volunteered to be interviewed about their experiences of transition from active military duty to civilian life. A purposive sampling method was adopted as opposed to random sampling which is consistent with the qualitative paradigm followed. Interpretive Phenomenological Analysis (IPA) is an idiographic approach concerned with understanding phenomena in particular contexts; therefore, a small sample size of eight was permissible (Smith et al., 2009).

As mentioned, the veterans were recruited from a specific veterans support service. This was a local, charity-led, organisation which offered volunteer

opportunities and practical support to veterans, as well as a chance to meet other veterans.

The inclusion criteria required that participants were male and had: been veterans/service leavers for at least one year, served in the British Army, and had been on at least one operational tour. Any participants which had been medically discharged or had acquired a disability were not approached due to concerns that their transition process may be significantly different to those who had decided to leave or had served a full military career (twenty-two years). The names of the participants have been changed in order preserve anonymity.

A total of eight participants were identified in the initial recruitment stage. A table of participant demographics has not been included to protect anonymity. There was a wide variety of ages amongst the participants, the mean being forty-three years (with a range of: twenty-five to sixty-six years). There were various reported reasons for leaving the Army, including a commitment to relationships and having served a full military career. Variability was also observed in the average length of time since the veteran had left the Army and taken part in the interview, with the mean being eight and a half years (range: one and a half to twenty-three years). For some participants many years had passed since leaving the Army and taking part in the study; however, in line with the IPA, it is still the person's own perception of their experience as well as how the individuals have since made sense of the "phenomenon" that this study is interested in.

All but one of the participants was of British ethnicity, and there was a range of countries that participants had served in active duty/operation in, including: Afghanistan, Northern Ireland, Iraq and Kosovo.

Each participant was approached by the manager of the veterans support service and given an “Information Sheet” (Appendix F). This information sheet included the researcher’s contact details in case they had any further questions or in case they would like to take part in the study. When contacted by a participant, the researcher arranged a time to meet to conduct the interview.

2.2.4 Materials

A copy of the semi-structured interview schedule, utilised in this study, can be found in Appendix G. The schedule aimed to elicit participants “real life experiences of transition” as this addresses the main aim of this study. Further to this, the schedule also enabled participants to discuss their experiences of the type of support, if any, they received. The schedule was developed according to guidelines by Smith et al. (2009); a copy of which can be found in Appendix H. As suggested in the guidelines for constructing a semi-structured interview, an additional researcher reviewed the schedule. A clinical psychologist acted as the additional researcher.

2.2.5 Interview procedure

Semi-structured interviews were conducted by the lead researcher in February 2013. All of the participants were interviewed at the veteran’s service, and consent forms were completed before the interviews commenced (see Appendix

I). The interviews lasted between thirty and sixty minutes, they were recorded by dictaphone and then transcribed verbatim.

2.2.6 Analysis

The principles of IPA (Smith et al., 2009) were adopted to analyse the interview transcripts. IPA is concerned with how people make sense and apply meaning to their experiences. It is phenomenological, which means it involves detailed examination of the real life, lived, experience and explores the individual's personal account and perception of an event (Smith & Osborn, 2008). It is interpretative in that it attempts to understand the meaning behind the accounts. The approach also remains mindful of the double hermeneutic in the interpretation of the data, with the position of the researcher being important.

Further detail on the guidelines followed to complete the analysis, alongside two extracts from analysed transcripts, can be found in Appendix J. In addition, an audit trail demonstrating the line by line coding of any emerging themes (sub-ordinate to super-ordinate) and the main construction of the overall themes can be found in Appendix K.

2.2.7 Position of the researcher

At the time of interviewing, the researcher was employed as a trainee clinical psychologist, on a clinical placement in a mental health team for the Ministry of Defence. The researcher was therefore aware of some of the terminology used in the military as well as various discharge procedures; but, the researcher was a civilian when conducting the interviews, rather than a member of the military

chain of command. During the research process, the interviewer was particularly influenced by models rooted in the engagement and motivation of people wanting to change, such as motivational interviewing techniques (Miller & Rollnick, 2002). Consequently, the researcher was likely to draw on some core skills in the ethos of the approach, such as reflective listening and building empathy in the research process. This compares favourably with the core skills outlined by Smith et al. (2009) for a semi-structured interview procedure.

2.2.8 Credibility of analysis

Guidelines pertinent to qualitative research were followed in order to ensure an appropriate and valid scientific review of the manuscripts (Elliott, Fischer &, Rennie, 1999). Credibility checks were conducted to ensure that the themes and categories compared well with other researchers' thoughts and ideas. One manuscript was therefore analysed by a fellow trainee clinical psychologist, this followed the same IPA guidelines as the lead researcher (Smith et al., 2009). An example of this analysis can be found in Appendix L. Finally, supervision was also sought from a qualitative researcher, to help support the constructing of the themes. This offered the opportunity to check that the lead researcher's coding was in line with others, who had not been heavily involved in the research; thus, ensuring that the themes remained grounded in the data.

2.3 Results

The IPA of the interview data revealed four main super-ordinate themes which captured the real life/lived experiences of the veterans interviewed; these are

summarised with their related sub-ordinate themes in Table 2. Prevalence was not the only factor in the selection of the emerging themes, but the richness and articulation of certain experiences was also considered. The super-ordinate title "constructing a new self-identity as a veteran" reflects the researchers' interest in the "psychological construct of the self"; whilst this was not overtly expressed by the veterans, it is connected to what they said and is, thus, in line with the process of IPA (Smith et al., 2009).

Table 2: Super-ordinate and sub-ordinate themes

	Super-ordinate themes	**Sub-ordinate themes**
Theme 1:	The consequences of leaving the Army:	I have lost my Army family.
	"I'm now on my own".	Abandonment by the Army.
Theme 2:	Them and us.	Do I fit in?
		Holding on to military life.
Theme 3:	Surviving civilian life.	The use of alcohol: a journey.
		Personal qualities that have facilitated re-engagement structure and direction.
Theme 4:	Constructing a new identity.	Identity as a veteran.
		Veteran's service provides a group identity.

2.3.1 Super-ordinate theme one: the consequences of leaving the Army: "I'm on my own now"

All eight participants spoke openly about the consequences of leaving the Army and joining civilian life. Underpinning this theme were the veterans' experiences of feeling abandoned by the Army.

2.3.1.1 Sub-ordinate theme one: "I have lost my Army family"

Many of the participants described the process of leaving the Army as emotionally distressing. Two emotions were commonly reported as being experienced by participants in transition, namely grief and guilt. These emotions were driven by the removal of a secure and safe attachment relationship in the veterans' lives. They saw the Army as family, security and safety, and leaving this relationship provoked strong emotional reactions.

With regards to the experience of grief, many participants compared their transition from the Army to "bereavement", in terms of feelings of grief and loss. Participants communicated a sense of loss at no longer belonging to military life. Jack vividly describes the emptiness felt when he left the Army:

> *A big piece of your soul is ripped away, there is a big emptiness, one minute you belong to something and the next you're an ex and this is a big piece of soul crushing (Jack, 161-164).*

Veterans also spoke about the loss of companionship and support that they had previously obtained from the Army. The cohesiveness and belonging is something that all veterans missed and the loss of this appeared to activate further negative emotional consequences, such as feelings of sadness.

Furthermore, veterans felt they were not able to recreate a sense of belonging in civilian working team environments – this prolonged the sense of grief further, as Tom describes:

> *I mean the police…they treat you exactly like civilians and some eighteen year old is filling in the same application as someone who has done twelve years in the Army (Tom, 260-264).*

On an interpretive level, the interview data revealed that the veterans also referred to the loss of military power and rank since leaving the Army. They referred to their rank and responsibility as something highly valued by themselves and the rest of the Army. Veterans experienced a sense of loss of the associated power, responsibility and identity that was attached to their military rank – they felt like it had been removed in the civilian world. A quote from John captures this experience:

> *Coming out of the Armed Forces was like a bereavement, I suddenly went from being a Sgt Major to a nothing and joining the rest of the people (John, 56-57).*

Feelings of guilt were also commonly expressed, arising from four of the eight veterans. These veterans acknowledged that they were no longer actively "being there" for colleagues as they were unable to do anything to help those left behind, since they had become civilians. Hank demonstrates just how powerful this sense of guilt was for him:

> *I had this overwhelming feeling of guilt. I think my breakdown was about not being around and not being able to do anything(Hank, 74-78).*

This guilty feeling also extended into some of the veterans' new lives as civilians; Tom in particular suggested that the feeling of guilt does not leave you whilst in new working roles:

> *When I was in the Specials, I was feeling so guilty about not helping in the Birmingham riots, but just watching on telly (Tom, 515-516).*

2.3.1.2 Sub-ordinate theme two: "abandonment by the Army"

Many of the interviewed veterans implied that they had been, or felt they had been, abandoned by the Army; they were now alone as civilians without Army support. This is clearly shown in the following quotes:

> *It's like you're gone out the door, that's it and there is this cry to get back in (Jack, 168),*

> *One day in the Army and the next I was out and had to get on with life(Lewis, 18).*

In addition, feelings of frustration with the Army, for not doing enough to prepare veterans for the emotionally distressing impact of transition, were also found. These feelings were compounded by feelings associated with being "kicked out" with no return; they felt that the Army was no longer interested in them. Lewis describes the limited support that he received in transition:

> *Yeah well in the military you got all your mates, mucker's and stuff, all banter. When you come out you got nothing, no support, no nothing (Lewis, 61-64).*

2.3.2 Super-ordinate theme two: "them and us"

This second overarching theme is underpinned by the perceived differences between veterans and civilians – this included feelings that were distinctively

different with regards to how they approached work and life. Veterans continued to hold on to, or made new links with, previous military mentalities which continued to endorse a “them and us” (civilian/veteran) division.

2.3.2.1 Sub-ordinate theme one: “do I fit in?”

It emerged from the veterans’ experiences that a feeling of “not fitting with a civilian view of the world” was underpinning their sense of isolation. Further analysis encapsulated a growing sense of dissatisfaction with civilian attitudes. Veterans couldn’t understand the way civilians approached their life and work. Veterans referred to their team existence in the military, where you worked hard and looked after each other in order to get things done; this was described as the general mentality of the Army. They all referred to this as being in stark contrast to the civilian way of being, as described by Jack:

> *In civvy street, it’s just a bunch of backstabbing, thieving, lying... they are all the same and you lose trust in society and you’re behind the door, curtains closed in the backroom (Jack, 135-137).*

Some veterans perceived the civilian world to be a threatening place and this was underpinned by feelings that civilians were untrustworthy and incomparable to people in the Army. Veterans were unable to turn off their in-built military training, such as the fight/flight response to manage perceived threats in the community. Jack’s quote demonstrates how his isolation was compounded by his retreat into his home where potential threat triggers would be limited:

> *I mean if you’re sitting in a room and got the curtain closed and there is noise and you can’t see out the window, your head will fill the gap, just retreat into a back room…isolation (Jack, 32-36).*

The interview data indicated a strong sense of feelings of “difference” in civilian society, as described by Paul:

> *You go for a run and feel that people are staring at you(Paul 69-70).*

Veterans referred to their set of unique skills, that were developed during their service with the Army, as being unrecognised in the civilian world. Two of the eight veterans described in detail the various courses that had attended and the skills they had built whilst in the Army. Moreover, they expressed a sense of superiority and popularity that they had achieved whilst doing this. However, it emerged, from their experiences, that this meant “nothing” in the civilian world, as described by John:

> *I mean I was highly qualified, a Sergeant Major, I had a lot of management skills, but they were only recognised in the Army itself and not really appropriate on civvy street (John, 16-20).*

2.3.2.2 Sub-ordinate theme two: “holding on to Army life”

There was a strong desire throughout the veterans’ experiences of wanting to embrace or continue military ways of life, this included continuation of the team mentality and maintaining familiar coping mechanisms such as the use of humour and alcohol. This reflects that the veterans utilise similar and familiar ways of coping. Veterans describe “having a go” at being civilian, or connecting with civilian working roles, but not enjoying it and retreating back to isolation or to what they know best. The following quotes describe the manner in which the veterans attempt to keep their Army life alive:

Can't get it with civvies, but I have an Army mate and we still got that squaddie manner (Hank, 55),

I helped at sea cadets and Army and I was back in the military environment (Jack, 214-215).

Furthermore, many veteran experiences, including military ways of responding to perceived threats or managing certain social situations, were deemed to be inappropriate to civilian cultural norms. This led to further isolation for veterans who were excluded by new social groups. John describes times when he was physically and verbally abusive, in his military career he was able to manage these situations, but this would be deemed problematic and less acceptable in civilian social environments:

When you leave the Army and this fight/flight cascades into civilian life, it stays with you and there's no way of reducing it (John, 115-118).

Veterans' experiences of their relationship difficulties were also centred on with regards to the continuation of military ways of coping with stress which are not deemed suitable by civilian ways. Veterans described that their partners would identify negative elements – this constant reminder of inappropriate behaviours consequently led to a strain on relationships; as demonstrated by Jack:

My better half said she liked my sense of humour as that's how I got on in the military but I didn't know when to turn it off and she had to keep telling me it was not appropriate to be funny all the time (Jack, 17-21).

2.3.3 Super-ordinate theme two: surviving civilian life

This super-ordinate theme is grounded in the veterans' experiences of coping and managing their transition out of the Army. It refers to some of the maladaptive coping strategies, including the use of alcohol, but it also considers the role of resilience. Finally, this theme highlighted the positive benefits of a specific veterans' support service.

2.3.3.1 Sub-ordinate theme one: the use of alcohol: a journey

All interviewed veterans spoke of their experiences of managing their alcohol intake whilst in transition. Many spoke of alcohol being central to the culture of the Army and saw their drinking behaviours continuing after leaving. This quote by Hank summarises the familiar culture of drinking:

> *There was a lot of alcohol around, especially when in the Army, big, big drinking culture and it was just like normal really (Hank, 57-58).*

All of the interviewed veterans utilised alcohol as a means of "coping" with distress, but there were differences between them with regards to the nature of the distressing situation that produced the drinking behaviours. Paul provides an example of his relationship with alcohol after being made redundant, and Tom focuses on how alcohol helped him manage his anxiety:

> *Second year found my feet, but got made redundant no fault of my own and went back to the drink (Paul, 75),*

> *I admit to turning to drink…I needed it to stop that fight/flight response coming in (John, 126-127).*

All of the veterans described changes in their drinking behaviours after their initial transition. Several years after leaving the Army these experiences had changed somewhat from a reliance on alcohol, to feeling better and able to manage their drinking whereby most didn't drink at all. These experiences reflect a transitional journey with alcohol. It was apparent that more supportive relationships helped the veterans to gain control in their life, such as finding new stable jobs or support from veteran services which meant that drinking alcohol, as a coping mechanism, was no longer required; to illustrate:

> *My missus soon snapped me out of it sharpish, or she was going to leave(Paul,76).*

2.3.3.2 Sub-ordinate theme two: personal qualities that have facilitated re-engagement

Several personal qualities were described by the veterans as helping them to manage their transition into civilian life. It was revealed that the "work ethic/attitude" was a common theme which supported veterans in "getting up and getting on with things". It was common for the interviewed veterans, such as John below, to describe themselves as hard workers who were willing to keep busy:

> *I was a hard worker and my manager described me as dynamic in my manner (John, 136-37).*

Similarly, the veterans spoke of the personal quality of being "pro-active" as helpful in the transition period. Within the spectrum of being pro-active there were some differences in how veterans used this quality to manage their journey. James for example discussed his experience of moving his family out of

the Army barracks before leaving the Army, he felt that this helped with integration into the community. In addition, Tom spoke of his experience of finding a job that utilised his skills and interests along with making contacts with civilians before he left the Army.

> *I found myself into a good neighbourhood and good community and into a good establishment (James, 24-30),*

> *I had set myself up in my last year… I had sorted a job, I had done a plumbing course (Tom, 9).*

2.3.3.3 Sub-ordinate theme three: structure and direction

The veterans described the support service they attended as beneficial in providing practical advice. Veterans spoke of the shock of adjusting to everyday civilian tasks, namely paying bills and finding somewhere to live. This is managed for personnel whilst in the Army; thus, the veterans felt they were unprepared for managing these tasks, as Paul explains:

> *I think at first it was mainly money worries, when you get paid that was it your rent and bills paid for, so that was quite difficult having to pay out for bills (Paul, 2-5).*

Three of the eight participants expressed feelings of being "lost" and needing direction when they left the Army. Whilst in the Army, the veterans existed in the hierarchal context of the military where direction and promotion were at forefront. In contrast, when out of the Army, these veterans spoke of struggling to manage their own direction in life with regards to employment and relationships. The veterans service supported them to feel like they had a sense

of purpose of "doing something" again. The following two quotes demonstrate these notions:

> *Knowing where to go with things…I mean with the veterans service it's been brilliant, the first time I've had proper help; I've had direction (Paul, 67-69),*

> *Well when I first started coming here we had a purpose, getting up every day and coming in, helping each other out, essentially like a military environment (Jack, 277-280).*

2.3.4 Super-ordinate theme four: constructing a new identity

This theme refers to veteran experiences of reconstructing their identity through the transition period, since leaving the Army. It represents the manner in which veterans attempt to merge their military identity and military context with new roles in a civilian working and home environment. It also refers to the attempts to re-capture a group or shared identity with military values, through the veterans' support service.

2.3.4.1 Sub-ordinate theme one: identity as a veteran

The veterans spoke about difficulties in fitting into a civilian world. The cumulative effect of isolation, limited recognition of skills and perceived differences in attitudes, led some participants to feel like they were "starting over" and needing to "find themselves again" in the bigger civilian, and almost alien, world; to illustrate, Paul notes:

> It was like the world just went big, took me three and half hours to drive back and I was like what do I do now (Paul, 45-45).

Many of the veterans had volunteered; it appears as though central to a veteran's identity is that they continue to help people as they did in the Army. This replicates a feeling of working for a worthwhile cause and making a difference, similar to that of being in the Army. The veterans had their own familiar military traits which they attempted to integrate with civilian norms which resulted in the formation of a new veteran identity; as such, Bill stated:

> *I like helping people at the veterans' service; I always help out people before myself (Bill, 212).*

Veterans view themselves as uniquely different from general civilians and they would not label themselves as "civilian". Instead their veteran identity has been constructed of traits from their military life such as "I am a hard worker" and"I can help people", but this identity is adapted into a civilian world. Veterans also need to integrate other important self concepts into their identity, or make adaptations to previous ones, in order to continue to function in the civilian world. Thus, it is important to ask for help and guidance when needed (described by Tom) and it is important to understand the differences amongst civilian people:

> *I didn't know about the mortgage process but found out about it, I didn't know how to run a business but found out about it (Tom, 444-445).*

2.3.4.2 Sub-ordinate theme two: veteran's service provides a group identity

The veterans expressed concerns about the lack of understanding of the military by civilians, this makes integration more difficult. Some of the veterans spoke of

how the specific veteran's service offered them familiar military traits, such as "camaraderie" and "banter", which are not experienced in civilian life. Furthermore, their experiences alluded to the creation and formation of a veteran group identity; centred on shared experiences of being in the Army and the re-construction of previous military ways of being:

> *It's the banter, camaraderie, you're not looked down upon and you're treated as equal – I love it (Lewis, 4).*

The veteran's service offered a place for emotional support allowing the veterans to feel part of something again, with people who have a shared and common experience, as demonstrated by James. Further to this, it provides a place where they can thrive using their previous military ways and whilst experiencing a team mentality and a sense of belonging:

> *It's a place for ex-service personnel, who can pop in and get involved. I have enjoyed sharing my knowledge and helping people. It keeps the helping mentality of the Army going (James, 212-215).*

Veterans spoke positively about the familiarity of being with individuals with shared common experiences which provided feelings of being understood. Consequently, the veterans felt good and able to cope, as described by Jack:

> *I came in when it was the anniversary of an incident that happened which I have a lot of guilt about, I said I might have to shoot off but would give it ten minutes to see how it went... but, the minute I got chatting to the lads I felt better, and that's how it is… (Jack, 123-128).*

Differences were present in the experiences of veterans within this shared support service; some commented on the communicative nature whilst others referred to the sense of belonging. This could be interpreted as the unique ways

in which the veterans were using the service to exist, survive transition and find themselves again in a civilian world.

2.4 Discussion

The aim of this present study was to explore the real life/lived experiences of UK Army veterans, in their transition from active military duty to civilian life. The study adopted a qualitative phenomenological approach to support more in-depth understanding of the subject area. Eight male veterans took part in a semi-structured interview, the data was then analysed using IPA techniques .Four super-ordinate themes emerged from analysis of the interviews: firstly, “The consequence of leaving the Army: I’m on my own now” reflects the veterans’ experiences of feeling isolated and abandoned since leaving the Army, coupled with general negative emotional consequences. Secondly, “Them and us” refers to the perceived difference and divide between civilian and veteran mentality. The third super-ordinate theme:“Surviving civilian life” was grounded in the veterans’ experiences of coping and managing their transition out of the Army. This reflects both maladaptive strategies, including the use of alcohol, as well as the role of resilience and the benefits of using specific veteran support services. The final super-ordinate theme was “Constructing a new Identity ”which referred to veteran attempts to merge a familiar military identity with new roles within a civilian working and home environment.

The veteran experiences suggest that the acknowledged presence of individual differences in the Army is limited; being a soldier was their identity and they lived in a “family” of soldiers. According to Arkin and Dobrofsky (1978), military

training strips you of civilian cultural norms and shapes self-concepts in line with the military. They further suggest that training embeds values of duty, honour and obedience, whilst also fostering the creation of a group mentality in recruits. These values directly conflict with the individualistic values embraced by Western society; consequently, when individuals leave the Army and return to civilian life, difficulties in reintegration occur (Demers, 2011).

Veterans return to an environment where a variety of different civilian people live, as a result there is a much broader scope of identities, values and attitudes. According to the veterans interviewed in this study, these perceived differences can cause difficulties in understanding social situations and in relating to colleagues in employment. No training is given to assist individual military personnel to return back to civilian life after leaving the Army. Consequently, veterans are faced with the challenge of re-constructing a new identity that is separated from the familiar Army mentality; this transition was difficult for all of the veterans interviewed in this study.

It is therefore challenging to reintegrate into a civilian identity; to illustrate, previous research conducted with US soldiers by Demers (2011) described that the returning soldiers were caught between the two cultures. This notion is echoed by the findings presented in this study whereby the veterans' experiences were full of perceived differences between military and civilian attitudes and cultural norms. Being a civilian meant being "out for yourself" whilst being in the military meant "being in a team". Consequently, it is difficult for veterans to integrate into a new way of life, that does not fit with how they

perceive the world or themselves. Many of the veterans described isolation as a way of managing these perceived discrepancies in attitudes.

Brewer and Gardner (1996) argue that our social roles are also closely linked with our identities, and our life story is mapped out by transition from one social role to another. In the present study, the veterans were experiencing a major role transition from being an Army soldier to a working civilian. The work roles we perform are thought to affect our self concepts, beliefs and how we see the social world; commitments to these roles are central and significant in our identity (West, Nicholson, Arnold, 1987). Not only were the veterans in the study changing working roles, but they were also leaving a social/cultural environment which was forcing them to connect with a new one. Baumeister and Mauraven (1996) propose that identity reflects the adaptation of the individual/self to the socio-cultural context. The self constructs a definition which allows the individual to get along reasonably well in the social environment. This was particularly prominent for veterans in this study, they generally described the experience as "starting over"; leaving the Army initiated them to reconstruct a new identity.

Alienation and the perception of being misunderstood and unappreciated are risk factors for ex-service personnel which contribute to their failures in accessing mental health services (Brewin, 2010). This, along with the attempts of veterans to re-create links to their past military way of life such as volunteering, helping others and re-creating a sense of belonging, helps to explain why veterans in this study greatly valued the specific veteran's agencies that they attended. These findings are in line with Hinojosa and Hinojosa's (2011) findings which demonstrated the importance of military friendships and

the reconnection of a “brotherhood” which provided what was “missing” for these veterans during the integration process.

In addition, the findings also concur with the literature on social identity theory by Tajfel (1981), who argues that individuals are motivated to belong to groups to give a sense of social identity: a sense of belonging to the social world. Furthermore, the theory proposes we divide the world into “them” and “us” based on a process of social categorisation. It mirrors the veterans’ attempts to distinguish themselves as different from civilians. The veterans in this study had started to re-create a “shared veteran identity” by attending the specific support group services. This was partially developed because it was built on the familiar military traditions which the veterans understood and felt comfortable with; it also re-created a sense of belonging to something again.

This further relates to the work of Yalom (2005), and his theory of universality, which suggests that a person’s distress is often compounded by feelings of uniqueness and social isolation. He argues that once brought together with people experiencing similar difficulties, it ameliorates any added distress by providing disconfirmation of the feelings of uniqueness. Furthermore, a sense of belonging to a shared group experience is also created (Yalom, 2005).

Previous research into family integration, for military veterans and spouses, focused on veterans with mental health problems (Evans, Cowlishaw, Forbes, Parslow, & Lewis, 2010; Sayers, 2011), it provided a useful clinical framework for understanding family integration and related problems. This study’s findings concur with their framework by demonstrating that veterans who have not been

diagnosed with mental health problems have similar familial integration difficulties.

Many of the veterans spoke of their experiences of using alcohol in civilian life, as a familiar way of coping with stressors as this was what they used when in the Army. This is in line with the findings of a report by Dandeker, Wessely and Iversen (2003) who suggested that heavy alcohol use in Army life results in difficulties and being unprepared for civilian life.

2.5 Methodological Considerations

A number of limitations with the current study will now be outlined. The sample was of Army male veterans and is therefore only representative of the experiences of this select group rather than inclusive of veterans from other branches of the Armed Forces. A further limitation relates to gender which is likely to be of interest to researchers and the military as previous military literature has highlighted gender differences in coping mechanisms (Maugen, Cohen, Ren, Bosch, Kimmerling, & Seal, 2012), particularly in relation to alcohol use which suggests that males tend to use more substances to manage their emotions. Consequently, a weakness of the current research is that it did not explore gender differences or similarities.

In addition, this research focused on a self-selecting sample of volunteers who offered to share their experiences, in an interview process, as a result of them accessing the veteran's support service. It is important to acknowledge that those veterans who were not able to share their experiences or take part in the study could have provided very different accounts of their experiences. This

notion should therefore be considered as it could have potentially led to a bias in the sample.

Finally, it is important to consider that only a small sample of Army veterans were considered in this study, all of which came from a specific geographical location. Furthermore, they were all attending a specific support service, this could potentially reflect other positivity bias towards the specific agency as the supportive management offered at this centre may not have been experienced by veterans at other centres.

2.6 Recommendations for Further Research

It is recommended that a similar study be repeated with veterans that have since left the Royal Navy and the Royal Air Force; this should also include women veterans. Findings from which would indicate whether the experiences of other service leavers are of a different nature whilst also allowing for gender differences and similarities to be examined.

The veterans interviewed in this study were all attending a specific veteran's support agency. Further investigation or evaluation into the benefits and effectiveness of long-term positive/negative outcomes of attending these specific services is also warranted. A service approach may be necessary to further explore how specific veteran support services contribute to the re-creation of a sense of belonging.

Finally, the present study highlighted how a veteran's experience influences the construction of a new identity and the transition from a military to a civilian way

of life. This also warrants further exploration. It may be interesting to hear the experiences of the families of service leavers, both in terms of how they feel their loved one has adapted since leaving the military as well as knowledge about their personal transition experiences.

2.7 Clinical Recommendations

It is important to acknowledge that this study utilised only eight participants, from a selected geographical area, it is therefore difficult to suggest any fundamental clinical recommendations. However, the themes developed from the veterans' data may offer potential ideas for additional training that the military may want to consider incorporating into existing packages of care.

The study clearly demonstrates the need for better psycho-education and training that focuses on emotionally preparing a service leaver for transition. It has been identified that veterans reported feeling isolated after leaving the Army which left them with negative emotional consequences. The military may want to consider incorporating elements of emotional awareness training whilst also providing accounts of transition experiences within their existing re-settlement package; this could focus on the support that is available after leaving the Army.

The military may also wish to consider creating supportive "leaver groups", to help keep military friendships alive and limit isolation; as this was a commonality reported by all of the veterans in this study. Furthermore, this study has highlighted the potential benefits to emotional well-being from embarking on specific veteran support services that are available outside of the military. The

Army may want to consider offering leaflets and contact details of such local services.

Finally, this study adds richer detail to local health service initiatives, such as that of NHS Bedfordshire which recognises the need for more understanding about the needs of veterans. This study has not only highlighted the real life/lived experiences for personnel transitioning out of the Army, but it also details some of the challenges and difficulties associated with integrating into, and maintaining, a civilian life.

2.8 Conclusion

The findings from the presented study suggest that transition from a military life to civilian life is not without its challenges. Army veterans have reported difficulties in: adjusting to civilian cultural norms, re-creating a sense of belonging and in a reliance on traditional military ways of coping, such as the use of alcohol. This has contributed to feelings of isolation and problems in interpersonal relationships. Veterans' experiences of not feeling emotionally prepared for transition gives rise to new clinical recommendations for the military, whereby the incorporation of elements of further training into the existing resettlement packages should be considered.

2.9 References

Almond, N., Kahwati, L., Kinsinger, L., & Portefield, D. (2008). The prevalence of overweight and obesity among US military veterans. *Military Medicine, 173*, 544-550.

Arkin, W., &Dobrofsky, L. R. (1978). Military socialisation and masculinity. *Journal of Social Issues*, *34*, 151-168. doi: 10.1111/j.1540-4560.1978.tb02546

Baumeister, R. F., & Mauraven, M. (1996). Identity as adaption to social context and historical context. *Journal of Adolescence, 19*, 405-416.

Beder, J., Coe, R., & Sommer, D. (2011). Women and men who have served in Afghanistan/Iraq: Coming home. *Social Work in Health Care, 50*, 515-216. doi:10.1080/00981389.2011.554279

Brewer, M., & Gardner, W. (1996). Who is this “we”? Levels of collective identity and self-representations. *Journal of Personality and Social Psychology, 71*, 83-93.

Brewin, C. R., Garnett, R., & Andrews, B. (2011). Trauma, identity and mental health in UK military veterans. *Psychological Medicine, 41*, 1733-1740. doi.10.1017/S003329171000231X

Dandeker, C., Wessely, S., & Iversen, A. (2003). *Improving the Delivery of Cross Departmental Support and Services for Veterans*. Ministry of Defence. Retrieved from http://www.veteransuk.com/pdfs/publications/misc/kingscollege_report_jul_03.pdf.

Demers, A. (2011). When veterans return: The role of community in reintegration. *Journal of Loss and Trauma, 16*, 160-179. doi: 10.1177/0022167812472395

Drumment, A. R., Coleman, M., & Cable, S. (2003). Military families under stress: Implications for family life education. *Family Relations, 52,* 279. doi: 10.1111/j.1741-3729.2003.00279.x

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229. doi: 10.1348/014466599162782

Evans, L., Cowlishaw, S., Forbes, D., Parslow, R., & Lewis, V. (2010). Longitudinal analysis of family functioning in veterans and their partners across treatment. *Journal of Consulting and Clinical Psychology, 78,* 611-622. doi: 10.1037/a0020457

Hinojosa, R., &Hinojosa, M. (2011). Using military friendships to optimise post-deployment reintegration for male Operation Iraqi Freedom/Operation Enduring Freedom veterans. *Journal of Rehabilitation Research &Development, 48,* 1145-1157. doi: 10.1682/JRRD.2010.08.0151

Hogue, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services and attrition from military service after deployment to Iraq or Afghanistan. *The Journal of the American Medical Association, 295,* 1023-1032. doi: 10.1001/jama.295.9.1023

HM Government. (2010). *Securing Britain in an Age of Uncertainty: The Strategic Defence and Security Review*. Retrieved from http://www.offcial-documents.gov.uk.

Iversen, A., Nikolaou, V., Greenberg, N., Unwin, C., Hull, L., Hotopf, M., Dandeker, C., Ross, J., & Wessley, S. *(2005).* What happens to British veterans when they leave the Armed Forces? *European Journal of Public Health 15,*175-184.doi: 10.1093/eurpub/cki128

Iversen, A., Dyson, C., Smith, S., Greenberg, N., Walwyn, R., Unwin, C., … Wessley, S. *(2005).* Goodbye and good luck: The mental health needs and treatment experiences of British ex-service personnel. *The British Journal of Psychiatry, 186,* 480-486. doi: 10.1192/bjp.186.6.480

Mansfield, A .J., Bender, R. H., Hourani, L. L., & Larson, G. E. (2011). Suicidal or self-harming ideation in military personnel transitioning to civilian life. *Suicide and Life-Threatening Behaviour, 41*, 392-405. doi: 10.1111/j.1943-278X.2011.00039.x

Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change*. New York, NY: Guilford Press.

Maugen, S., Cohen, B., Ren, L., Bosch, J., Kimmerling, R., & Seal, K. (2012). Gender differences in military sexual trauma and mental health diagnoses among Iraq and Afghanistan veterans with post-traumatic stress disorder. *Women's Health Issues, 22,* 61-66. doi: 10.1016/j.whi.2011.07.010

NHS Bedfordshire. (2012). *Veterans Mental Health Needs Assessment*. Bedfordshire: National Health Service.

Peebles-Kleiger, M. J., & Kleiger, J. H. (1994). Reintegration stress for Desert Storm families: War time deployments and family trauma. *Journal of Traumatic Stress, 7,* 173-194. doi: 10.1002/jts.2490070203

Sayers, S. L. (2011). Family integration difficulties and couples therapy for military veterans and their spouses. *Cognitive and Behavioural Practice, 18,* 108-119.

Smith, J., & Eatough, V. (2007). Interpretative phenomenological analysis. In E. Lyons & A. Coyle (Eds.), *Analysing Qualitative Data in Psychology* (pp.34-50). London: Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis. Theory, Method and Research*. London: Sage.

Smith, J., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods* (pp.51-80). London: Sage.

Snell, F., & Tusaie, K. R. (2008). Veterans reported reasons for seeking mental health treatment. *Archives of Psychiatric Nursing, 22*, 313-314. doi: 10.1016/j.apnu.2008.06.003

Staden, S. A. (2007). Transition back into civilian life: A study of personnel leaving the UK Armed Forces via “Military Prison”. *Military Medicine, 172,* 925-930.

Tajfel, H. (1981). *Social Groups and Social Categories: Studies in Social Psychology*. Cambridge: Cambridge University Press.

Walker, S. (2010). Assessing the mental health consequences of military combat in Iraq and Afghanistan: A literature review. *Journal of Psychiatric and Mental Health Nursing, 17,* 790-796. doi: 10.1111/j.1365-2850.2010.01603.x

West, M., Nicholson, N., & Arnold, J. (1987). Identity changes as outcomes of work-role transitions. In T. K. Honess & K. Yardley (Eds.), *Self and Identity: Perspectives Across the Lifespan* (pp. 287-303). Boston: Routledge.

Yalom, I. D. (2005). *The Theory and Practice of Group Psychotherapy* (5th Ed). New York: Basic Books.

CHAPTER THREE

EXPERIENCES OF BEING A CIVILIAN WOMAN TRAINEE CLINICAL PSYCHOLOGIST WITHIN A MILITARY CLINICAL PLACEMENT: MY RESEARCH JOURNEY

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3.0 Introduction

At the height of my research journey; namely conducting interviews and creating transcriptions, I was also on placement with the military and more specifically working in a community mental health team for the Ministry of Defence. My clinical case load therefore consisted of clients with mental health difficulties from all three services of the armed forces; Army, Royal Air Force, and Navy, across a selected geographical area. The multi disciplinary team I was working with consisted of: A Psychiatrist, Community Psychiatric Nurses, Social Workers and two Clinical Psychologists. Some members of the team were in uniform and actively serving in the Army but the vast majority were veterans and civilians. Some of the veteran professionals (nurses and psychiatrist) had high positioned ranks in their time in the Army but had subsequently left to be civilian. They were not in transition and considered to be out of the Army for some time, post ten years.

My research explored the lived experiences of UK Army veterans' transition from active military duty to civilian life. Eight semi-structured interviews were carried out with veterans attending a specific veterans support and advice agency. Interview transcripts were analysed utilising Interpretive Phenomenological Analysis and the following themes emerged from the data: 'The consequences of leaving the Army: I'm on my own now',' 'Them and Us', 'Surviving Civilian life' and 'Constructing a new identity.'

3.1 Aims

The aim of this paper is to discuss my experiences and reflections of a military placement and the implications this had on my research journey. As I became more experienced and gained knowledge about the military, this significantly affected my perceptions of soldiers and veterans. It increased my understanding about their way of life and affected how I interpreted some of the data obtained from the interviews in my research. I also discuss how I used some of my research findings in my clinical work, as well as my reflections on how applicable the service implications recommended in the empirical paper are within a military service setting.

3.2 Office Dynamics on Placement

The team structure and balance between uniformed and civilian members of staff, many of whom had vast amounts of military experience, created interesting dynamics at the team meetings. I also noticed that despite there being a number of women in the team, what they had to offer was often lost and meetings were dominated by the arguing male colleagues' voices. A number of times I had something to add to a discussion but felt my voice would not be heard by others and so held back. On reflection I noted that perhaps women's voices were silent due to the dominance of the male patriarchal context of the military setting. In addition, I noticed quieter members of the team often appeared to be struggling and looking at their watches when other members of the team were continuing to talk for long periods of time.

I reflected on these issues in supervision and discussed the patriarchal power of male members of the military. Despite many of the team members now being

civilian, it appeared standard military ways of being, such as governing meetings, continued to be present in their current working life. This links well with some of my own research findings; veterans interviewed often discussed the need and desire to make links with their previous military life and continue a sense of belonging to something after leaving the Army. For those members of the team no longer active in the Army, it appeared they were making links by progressing with a career still inside the military. Apart from deployment and operational tours, they continued to work in a military context.

As well as the team meetings, there were also comments made in and out of the office about being a ‘student’ and a ‘civilian girl’. This often made me annoyed but also left me feeling de-valued, de-graded as a woman and as a trainee psychologist. Starting placement in the military was like entering into a new world. It was like learning a new language in terms of specific phrases used, including the rank systems and different regiments and what their specific roles were. Alongside this was learning about the lived experiences of fighting and sometimes killing for a living. Having never worked in the military before, I felt this was something that I was just not prepared for and it really shocked me how different the military world is compared to a civilian one.

In my first few weeks on placement I felt very out of my depth with the realisation that military life and working in a military context was so different from what I was used to. I believe this however added to my empathy and understanding regarding what the veterans was telling me in the research interviews. When reading the transcripts, I could really relate and understand where participants were coming from in terms of some of the experiences they were sharing, such

as comparing their transition and leaving the Army to leaving home and leaving a close family unit. Having seen for myself the close unity of uniformed members of staff and the existence of camaraderie, I had a better mental picture of the lived experiences of some of the veterans I had interviewed during my research. As well as providing essential contextual understanding, it helped submerge me deeper into some of the data in the transcripts when it came to carrying out the analysis.

3.3 Individual Client Work on Placement

The influence of stigma is huge in the military. Every client I saw for psychological therapy on clinical placement came with concerns about attending a mental health appointment. These anxieties and concerns were rooted in the fear of the stigma of attending mental health services and how this might look to their peers. Promotion is a big part of a military hierarchal context and concerns were raised as to how it would look unfavourably for future promotion opportunities if they were being seen by the mental health team. Further to this, many of the soldiers or clients seen for therapy by myself had common core beliefs regarding their identity and it was important for them to be seen as ‘strong’. They had been trained in this way and it had become a part of their identity as a solider feeling that this was their job and they should be able to be resilient.

I reflected on this issue of a ‘strong identity’ in line with some of my findings in my research. One of the major themes to arise in analysis was the challenge of managing alcohol intake whilst in transition from the military. However, many of the veterans interviewed also spoke of the military culture being dominated by

alcohol; this is how soldiers managed stressful experiences rather than seeking further support from mental health services. This is fitting with keeping a strong front/identity and it being important to be seen that they are able to manage their jobs.

Some clients in my clinical placement questioned how well I could understand them; after all in their eyes, I was 'just' a civilian, so what did I know about operational tours. It often struck me how far removed from the military world I felt. This on refection was not just the case for me but would be the same for much of the civilian population. This also helped me reflect on my research findings as some of the veterans interviewed referred to questions being asked by civilians about their Army careers and how they perceived this as irritating. The questioning by civilians could be a way of understanding and getting to know more about the military. I know from my individual experiences of working in the military that at first it can be experienced as an 'unknown entity' and this can create inquisitive questioning by people not accustomed to a military life.

In individual client work, I felt out of my depth and struggled at times to know what a psychologist in training could offer a military population. Then several weeks into my placement I thought less about applying certain therapeutic models and interventions but really started to focus on my basic engagement skills. I referred back to the skilled helper model by Egan (1975) who outlined a three stage model in which he defined numerous sets of skills that the therapist must deliver in order to build a healthy therapeutic alliance. I realised I definitely felt more competent in utilising these skills; minimal encouragers, summarising, empathy, mirroring, to name but a few. I also heavily relied on formulation work

and taking time to give a client space to discuss their difficulties and background. It was clear that after several sessions I had engaged a few of my clients and they were beginning to explore more about themselves. It therefore took time for a trusting therapeutic relationship to develop. I have learnt that no matter what population you work with or how challenging they may seem to you, basic engagement skills are essential in developing initial therapeutic relationships coupled with a detailed formulation for an individual. The understanding that this gave some of the soldiers about themselves who had never had the opportunity to have this kind of therapeutic space allocated to them was substantial.

3.4 Implications for My Position as a Researcher

I reflected on the position of the veterans being interviewed in my research study and how they must have felt sharing their experiences with someone whom they knew was a trainee psychologist. I wondered if they felt shame or stigma in discussing their experiences with a researcher based in the mental health system. One of the major themes to arise from my research was about being 'understood' and the veterans interviewed in my research felt they could only do this with people who had served with the Army. Further to this, they felt they could only speak about certain things with people who might listen. This is likely to have influenced how much they told me or shared during interviews, bearing in mind my lack of affiliation with the military. This is an assumption however, as participants did not know my background. I could also imagine that these factors may have accumulated to the research process feeling less comfortable for the veterans in talking to an 'outsider' about their core issues. However, I did

not believe this had too great an impact on what the veterans shared with me, judging by the length of time the interviews lasted for and for the rich and in-depth detail that was provided.

I did not specifically ask veterans about their time in the military, mental health problems or operational tours. The aim was to discuss their transition from the Army and I also think this helped in enabling them to open up and let more of their experiences be shared. I felt if I had asked them more about their experiences inside the military, this would have been met with more resistance, bearing in mind my experiences on clinical placement. Many of my clients felt they could not share or be understood by a civilian female at least until a trusting relationship was developed.

However, it would be of interest to find out and explore the veterans' experiences of being interviewed for research, perhaps with a survey rather than an interview, in order to find out if there were some aspects of their experiences they really did not want to discuss. I believe this to be something to consider for all qualitative research with populations that are specifically vulnerable to stigma and shame. It highlights the importance of appropriate and instructive information sheets, highlighting confidentiality and awareness of research issues before participants are interviewed so they know their information is for research purposes only.

I also believe that there may have been potential benefits for the veterans who participated in my research. The individually allocated space to discuss their transition experiences may have been beneficial in empowering participants to have a 'voice', something they may never have had before. All of the veterans

interviewed were keen to pursue career opportunities that involved helping others and they knew that one of the aims of the research was to help improve future support services. Participating in research could have added to veterans' self-esteem and sense that they were making a difference.

3.5 Using my Research on Placement

I used my research findings in my clinical placement to share ideas with some of my clients (soldiers) who were beginning transition journeys. They really valued my sharing of the research. I feel this added to the therapeutic relationship as it promoted understanding and the fact I was listening and interested in their world. They had already experienced differences in civilian attitude and I suggested integration needed to start early. This suggestion was prompted from some of the helpful efforts suggested by veterans in my research.

One of my clients for example who has just left the Army was finding it hard not being with his colleagues anymore and felt isolated. Since working with me, he had arranged a catch up with a few Army peers and really enjoyed himself. This suggestion for my client to re-connect with fellow Army peers was prompted by the significant positivity the veterans in my research experienced from being with others and with a shared experience in the veterans service. My client on placement commented on how beneficial he found it making the links back to his military life. On reflection, I was pleased to see how the research could be applied to daily clinical settings.

The applicability of research to a clinic setting has really struck me throughout my research journey. My research in particular is grounded in the lived experiences of transition out of the Army. This relates to a growing population in

line with government guidelines/policy in shrinking the armed forces and compulsory redundancies. It means more people are likely to enter transition which was something I found whilst on my clinical placement. Sharing findings, themes and experiences from the interviews in my research with veterans who have 'survived' transition out of the Army proved very valuable to people who were about to experience it themselves. Some clients really were attentive to what I had to say about my research, were interested and wanted to know more about the experiences. In one sense the research findings acted as a preparatory guide and one client thanked me for helping them know what to expect, something not provided by the Army.

I wondered or considered what was useful for my transitioning clients about hearing others' experiences and reached a conclusion it was about reducing the 'black hole' or shock about leaving the Army and entering the unknown civilian world again. It gave something for soldiers to hold on to, normalise experience and increase awareness. I am a strong believer in supporting someone to increase their awareness of, not only what is happening for them in their psychological and general well being, but the wider context. I have found it really offers someone choice, and in this case it could prevent some of the more negative themes that arose in my research, such as isolation for veterans, as they could make more active efforts to prevent it. For soldiers about to enter transition, it could mean they become involved in networks with other leavers, make steps to integrate early, join civilian courses; all information gained from my research.

3.6 Conclusion

It was valuable for my own personal development to observe the positives that arise from the research process. It felt like the journey from proposal, ethics, interviews and transcripts which at times was stressful, time consuming and demanding, was all worthwhile. This part of the journey was often detached from daily clinical work; which is where my main interests and passions lie. The applicability of my research gave me hope and tools to help/support soldiers. Further to this, it helped to change my opinion about research, my thoughts about it being arbitrary and detached from clinical everyday realities changed throughout my research journey. I was fortunate to be on a military clinical placement at the time of formatting results and therefore was able to apply and share findings. It does highlight the need for dissemination and implications of research to reach a clinical setting. Any further research I complete would be followed up with teaching and implementation guidelines to allow for this.

References

Egan, G. (1975). *The Skilled Helper: A Model for Systematic Helping and Interpersonal Relating*. Monterey, California: Brooks/Cole Publishing.

Appendix A: Author Guidelines for Submission to the Journal of Occupational Health Psychology

Manuscripts submitted for publication consideration in the *Journal of Occupational Health Psychology* are evaluated according to the following general criteria:

- Mastery of the relevant literature
- Theoretical/conceptual framework
- Measures of key constructs
- Research design
- Data analysis
- Interpretations and conclusions
- Writing style (clarity)
- Appropriateness of topic for *JOHP*
- Theoretical contribution to occupational health psychology
- Practical implications for occupational health psychology

While the journal doesn't have restrictions regarding manuscript page length, typical submissions are 30 to 40 double-spaced pages in length, with up to 4–6 figures and 3–4 tables. Extra figures, tables or additional material can be placed in a "supplementary material file."

Submission letters should include a statement regarding any possible conflict of interest in conducting or reporting of their research and a statement of compliance with APA ethical standards. Authors are also encouraged to suggest up to five reviewers who are especially qualified to review their work and who would not have a conflict of interest in serving as a referee.

Masked Review Policy

The journal accepts submissions in masked review format only.

Each copy of a manuscript should include a separate title page with author names and affiliations, and these should not appear anywhere else on the manuscript. Furthermore, author identification notes should be typed on the title page. Authors should make every effort to see that the manuscript itself contains no clues to their identities.

Manuscripts not in masked format will not be reviewed.

Please ensure that the final version for production includes a byline and full author note for typesetting.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Checklist for Manuscript Submission before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.

Below are additional instructions regarding the preparation of display equations and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Submitting Supplemental Materials

APA can now place supplementary materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

Journal Article:
Herbst-Damm, K. L., & Kulik, J. A. (2005). Volunteer support, marital status, and the survival times of terminally ill patients. *Health Psychology*, *24*, 225–229. doi: 10.1037/0278-6133.24.2.225

Authored Book:
Mitchell, T. R., & Larson, J. R., Jr. (1987). *People in organizations: An introduction to organizational behavior* (3rd ed.). New York, NY: McGraw-Hill.

Chapter in an Edited Book:
Bjork, R. A. (1989). Retrieval inhibition as an adaptive mechanism in human memory. In H. L. Roediger III & F. I. M. Craik (Eds.), *Varieties of memory & consciousness* (pp. 309–330). Hillsdale, NJ: Erlbaum.

Graphics

Graphics files are welcome if supplied as Tiff, EPS, or PowerPoint files. The minimum line weight for line art is 0.5 point for optimal printing.

When possible, please place symbol legends below the figure instead of to the side.

Original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay

- $255 for one figure
- $425 for two figures
- $575 for three figures
- $675 for four figures
- $55 for each additional figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including, for example, test materials (or portions thereof) and photographs of people.

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Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

Download Disclosure of Interests Form (PDF, 38KB)

Authors of accepted manuscripts are required to transfer the copyright to APA.

Download Publication Rights (Copyright Transfer) Form (PDF, 83KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the

confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on their website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

APPENDIX B: A Copy of the Methodological Quality Checklist

Quality Assessment Scale

Question responses: Yes, No, Partial, Not Applicable

1) Is the hypothesis/aim/objective of the study clearly described?

2) Are the main outcomes to be measured clearly described in the Introduction or Methods section?

3) Are the characteristics of the patients included in the study clearly described ?

4) Are the interventions of interest clearly described?

5) Are the distributions of principal confounders in each group of subjects to be compared clearly described?

6) Are the main findings of the study clearly described?

7) Does the study provide estimates of the random variability in the data for the main outcomes?

8) Have all important adverse events that may be a consequence of the intervention been reported?

9) Have the characteristics of patients lost to follow-up been described?

10) Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?

11) Is interpretation consistent with results?

12) Are the limitations, addressing multiple sources of bias reported?

External validity

13) Were the subjects asked to participate in the study representative of the entire population from which they were recruited?

14) Were those subjects who were prepared to participate representative of the entire population from which they were recruited?

13) Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive?

Internal validity - bias

15) Was an attempt made to blind study subjects to the intervention they have received?

16) Was an attempt made to blind those measuring the main outcomes of the intervention?

17) In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls ?

18) Were the statistical tests used to assess the main outcomes appropriate?

19) Was compliance with the intervention/s reliable?

20) Were the main outcome measures used accurate (valid and reliable)?

Internal validity – confounding (selection bias)

21) Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population?

22) Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same period of time?

23) Were study subjects randomised to intervention groups?

24) Was the method used to generate random allocation sequence appropriate?

25) Was the method of random allocation stated, who enrolled participants, who assigned participants to interventions?

26) Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable?

27) Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?

28) Were losses of patients to follow-up taken into account?

29) Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%?

APPENDIX C: Results of the Quality Checklist

Table of Quality Assessment

Reporting

Study	Q1: Aim clearly described	Q2: Outcomes clearly described	Q3: Patients characteristics clearly described	Q4: Interventions clearly described	Q5: Principal confounders clearly described	Q6: Main findings clearly described	Q7: Random variability for the main outcome provided	Q8: Adverse events reported	Q9: Lost to follow up reported	Q10: Actual p-value reported	Q11: Interpretation consistent with results	Q12: Limitations reported
Simpson et al. (2004)	yes	Yes	yes	Yes	yes	yes	No	no	yes	No	yes	yes
James (1999)	yes	Yes	yes	Yes	no	yes	No	No	no	No	yes	no
Dennis et al. (1999)	Yes	Yes	yes	Yes	yes	yes	Yes	No	yes	No	yes	yes
Bowles (2006)	Yes	Yes	yes	Yes	yes	yes	Yes	no	No	Yes	yes	yes
Trent and Stevens (1995)	Yes	Yes	Yes	Yes	yes	Yes	Yes	no	yes	Yes	yes	yes
Earles et al. (2007)	Yes	Yes	yes	Yes	yes	yes	No	no	yes	No	yes	yes
Hunter et al. (2008)	Yes	Yes	yes	Yes	Yes	yes	Yes	No	yes	Yes	yes	yes
Davis (1996)	Yes	Yes	yes	yes	yes	yes	No	No	yes	No	yes	yes
Stewart et al. (2011)	Yes	Yes	yes	yes	No	yes	No	No	yes	No	yes	yes
Shay et al. (2009)	Yes	Yes	Yes	yes	yes	yes	Yes	yes	yes	Yes	yes	yes
James et al. (2001)	Yes	Yes	Yes	No	No	yes	No	No	yes	No	yes	yes

External validity and Bias

Study	Q11: Sample asked to participate representative of the population	Q12: Sample agreed to participate representative of the population	Q13: Staff participating representative of the patient's environment	Q14: Attempt to blind participants	Q15: Attempt to blind assessors	Q16: Data dredging results stated clearly	Q17: Analysis adjusted for length of follow up	Q18: Appropriate statistics	Q19: Reliable compliance	Q20: Accurate outcome measures
Simpson et al. 2004	Yes	Yes	partially	no	n/a	n/a	Yes	Yes	yes	Yes
James (1999)	yes	Yes	partially	no	n/a	n/a	No	partially	yes	partially
Dennis et al. (1999)	yes	Yes	Yes	No	No	n/a	No	yes	no	yes
Bowles (2006)	yes	Yes	partially	No	n/a	n/a	Yes	Yes	yes	yes
Trent and Stevens (1995)	Yes	Yes	Yes	No	No	n/a	Yes	Yes	yes	Yes
Earles et al. (2007)	yes	Yes	Partially	No	n/a	n/a	Yes	yes	yes	yes
Hunter et al. (2008)	yes	Yes	Partially	yes	No	n/a	No	yes	yes	yes
Davis (1996)	yes	Yes	partially	No	n/a	n/a	Yes	yes	yes	Yes
Stewart et al. (2011)	no	No	No	no	n/a	n/a	No	Yes	yes	yes
Shay et al. (2009)	yes	Yes	partially	yes	No	N/a	No	Yes	yes	Yes
James et al. (2001)	yes	Yes	partially	No	No	n/a	No	yes	yes	yes

Selection bias and power

Study	Q21: Same population	Q22: Participants recruited at the same time	Q23: Randomised?	Q24: Method of randomisation reported	Q25:Assignment detail?	Q26: Adequate allocation concealment?	Q27: Adequate adjustment for confounders?	Q28: Loss of follow up reported?	Q29: Power calculation was there one?
Simpson et al. (2004)	no	n/a	No	n/a	n/a	n/a	no	yes	no
James (1999)	no	n/a	No	n/a	n/a	n/a	no	no	No
Dennis et al. (1999)	yes	Yes	Yes	yes	Yes	no	no	no	no
Bowles (2006)	no	n/a	No	n/a	n/a	n/a	no	yes	no
Trent and Stevens (1995)	yes	Yes	No	n/a	n/a	n/a	yes	no	no
Earles et al. (2007)	no	n/a	No	n/a	n/a	n/a	no	yes	no
Hunter et al.(2008)	yes	Yes	Yes	yes	Yes	yes	no	yes	yes
Davis (1996)	yes	n/a	No	n/a	n/a	n/a	no	yes	No
Stewart et al. (2011)	no	Yes	No	n/a	n/a	n/a	no	yes	no
Shay et al. (2009)	Yes	Yes	Yes	yes	Yes	yes	no	yes	no
James et al. (2001)	yes	Yes	No	n/a	n/a	n/a	no	yes	no

Study	Score	Percentage
Simpson et al. (2004)	33/50	66%
James (1999)	21/50	42%
Dennis et al. (1999)	40/60	66.6%
Bowles (2006)	35/50	70%
Trent and Stevens (1995)	42/54	77.7%
Earles et al. (2007)	32/50	64%
Hunter et al. (2008)	50/60	83.3%
Davis (1996)	35/50	70%
Stewart et al. (2011)	26/50	52%
Shay et al. (2009)	51/60	85%
James et al. (2001)	31/50	62%

APPENDIX D: Author Guidelines for ‘The British Journal of Psychology’

Author Guidelines

The Editorial Board of the British Journal of Psychology is prepared to consider for publication:

(a) reports of empirical studies likely to further our understanding of psychology

(b) critical reviews of the literature

(c) theoretical contributions Papers will be evaluated by the Editorial Board and referees in terms of scientific merit, readability, and interest to a general readership.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 8000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/bjp/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from here.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Supporting Information

BJOP is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at http://authorservices.wiley.com/bauthor/suppmat.asp

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10. Author Services

Author Services enables authors to track their article – once it has been accepted – through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit http://authorservices.wiley.com/bauthor/ for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.
11. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site:http://www.adobe.com/products/acrobat/readstep2.html. This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.
12. Early View

The British Journal of Psychology is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

Further information about the process of peer review and production can be found in this document: What happens to my paper?

APPENDIX E: Ethical Approval from the University of Coventry (Chapter Two)

Prof Jane Coad
Chair of Ethics Committee
Tel: (024) 7679 5831
Email: ethics.hls@coventry.ac.uk

28 January 2013

Dear Sir/Madam

Re: Ethical Approval – P4133

I am writing to confirm that **Ms Laura Blundell** has received ethical approval for the research project: *Military transition into civilian life: a phenomenological study with veterans in the United Kingdom*

The research project has addressed the main ethical issues appropriately, and has been approved by a member of the Faculty of Health & Life Sciences, Ethics and Governance Committee at Coventry University.

If you have any further queries please do not hesitate to contact me.

Yours sincerely

Prof Jane Coad

APPENDIX F: A Copy of the Information Sheet for Participants (Chapter Two)

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Professor Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

THE UNIVERSITY OF WARWICK

Coventry University

Participant Information Sheet

Many veterans have a successful and positive experience transitioning and re-adjusting from active military duty to civilian life. For some however, this transition can be challenging, isolating and a negative experience. There is very limited research which attempts to identify the specific challenges in a veteran's re-adjustment to civilian life and there is currently no research that explores the experiences of re-adjustment within a United Kingdom (UK) veteran population. We also know little about the experiences of veterans who access healthcare services, or whether if it is known if veterans are familiar with where to access support of needed.

This aim of this study is to investigate UK veteran's experiences of re-adjustment from active military duty to civilian life. Furthermore explore their experiences of healthcare services, if accessed. I am interested to know what has helped in re-adjustment, what is needed to make the transition to civilian life as successful as possible and the types of services needed to support veteran's physical and psychological well-being.

Your participation in this study will involve completing a signed consent form and a demographic questionnaire. The demographic questionnaire will include questions such as how long you have been a veteran and how long you were in active military duty.

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Chair of Department of Psychology
Professor Koen Lamberts BA BSc MSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

www.coventry.ac.uk

I will then invite you to participate in an interview. During this interview I will be asking you a series of questions about your own unique experience of what life has been like as a veteran, how you have re-adjusted and your experiences of healthcare services.

Your interview will be recorded using a Dictaphone in order to capture all the information. You will not be required to give any information you do not wish to share and have the right to stop the interview at any time without consequence. All information is kept confidential and no identifiable information will be shared. All documents with identifiable information including consent forms and audio CDs of the interviews will be securely locked in a filing cabinet at Coventry University.

When the information is written up no identifiable information of participants will be given and pseudonyms (false names) will be given. The lead researcher will have a copy of the pseudonyms and kept in a locked drawer. Once the research as has been submitted and examined all the data will be destroyed, written data kept at Coventry University will be stored in the locked cabinet and destroyed after a period of five years.

It is envisaged your participation should take 50 minutes of your time.

It is hoped that your participation in this study will shed new light into the unique experiences of transition from active military life to a civilian one. This information can then be used to inform and shape future support agencies in providing a unique service that is tailored to the specific needs of veterans.

It should be highlighted that although there are many potential benefits for participating in the study, as described above, taking part in the interview may be distressing if recalling potential stressful and traumatic memories.

In the event this occurs the researcher will provide immediate support with the option of terminating the interview. I will also be handing out an information leaflet with potential support services if required. Support and advice an also be accessed through the Contact Point.

I am conducting this research as student of the Clinical Psychology Doctorate from The Universities of Coventry and Warwick. The results of this study will hopefully be published in relevant academic journals and also be used for the researcher's doctoral thesis.

The research has been approved by the University Research Ethics Committee, Coventry University.

If you are happy to go ahead with participating in this study please could you sign the consent form provided and a time and date (convenient for you) will be arranged for the interview.

If you require anymore information the please don't hesitate to contact the researcher whose contact details can be found below. If you have any concerns about the way in which the study has been conducted, they should contact the Chair of the University Research Ethics Committee ethics@coventry.ac.uk

Researcher's Details
Laura Blundell, Trainee Clinical Psychologist
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APPENDIX G: A Copy of the Semi-Structured Interview Questions (Chapter Two)

Demographic Questions

1) How long were you in the Military for?
2) How long have you been out of the Military?
3) Why did you decide to leave the Military?
4) What is your age?
5) What countries did you serve in/Operational Tours whilst in the Military?
6) What is your current marital status?
7) Do you have any children?
8) What is your ethnicity?

1) Can you tell me about your experiences of transition between being in active Military duty to civilian life?

2) What were the challenges you experienced whilst in transition from active Military duty to civilian life?

3) Can you tell me about your experiences of how your transition affected your mental health and well being?

4) What were your experiences of what you found personally helped you cope and manage your transition from active Military duty to civilian life?

5) Can you tell me about your experiences of the support and healthcare systems since becoming a veteran?

APPENDIX H: A Copy of the Guidelines Followed in the Construction of the Semi-Structured Interview Questions (Chapter Two).

Constructing a scheduled for a semi-structured interview

Guidelines by Smith, Flowers and Larkin (2009)

- Having determined the overall area to be tackled in interview, think about the range of topic areas that you want your interview to cover.
- Put the topics in the most appropriate sequence.
- Think about how you might phrase appropriate, open questions relating to each topic. In phrasing it is important not to include closed questions and that do not make too many assumptions about the participants experiences.
- Verbal input from the interviewer can be minimal
- Questions should be prepared so that the participant is encouraged to speak at length
- Discuss the list of questions with someone else. You may well discover you have leading questions within your schedule and that you need to rethink these.

APPENDIX I: A Copy of the Consent Form for Participants (Chapter Two)

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Professor Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

THE UNIVERSITY OF WARWICK

Coventry University

Consent Form

Military transition into civilian life: a phenomenological study with veterans in the United Kingdom

I the undersigned give consent to participate in this research project. I understand that my participation will involve being interviewed about my experiences of transition from active military duty to civilian life. I also understand I will be completing a demographic questionnaire and signing this written consent form.

I understand my interview will be recorded by an audio recordable device. I understand that my identity will remain anonymous in the research so that my name will not be linked with any of the information presented. My recording and consent form will be locked in a confidential cupboard at Coventry University and then destroyed after five years.

If I volunteer to be in this study, I understand I may withdraw at any time without consequences of any kind and may also exercise the option of removing my data from the study. I may also refuse to answer any questions I don't want to answer and still remain in the study.

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Chair of Department of Psychology
Professor Koen Lamberts BA BSc MSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

www.coventry.ac.uk

- I confirm that I have read and understand the information sheet for the above study.
- I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.
- I agree to take part in the above research study.

Signature of participant:

Name of participant:

Date:

APPENDIX J: A Copy of the Guidelines Followed to Complete Data Analysis Alongside Two Extracts from Analysed Transcripts. (Chapter Two)

`Analysis using Interpretive Phenomenological Analysis'

Smith, Flowers and Larkin (2009)

Step 1: Reading and re-reading

This initial stage would involve reading and re-reading of the raw data and most commonly this would be the interview transcripts the rationale is for the researcher to immerse themselves in the data and the participant becomes the focus of analysis. Repeated reading also allows a model of the overall interview structure to develop and allows the researcher to gain understanding of how narratives bind certain sections of an interview together.

Step 2: Initial Noting

This stage of the analysis examines semantic content and language on an exploratory level. The researcher is expected to keep an open mind and note anything of interest within the transcript. There are no rules for what is commented on but the aim is to produce a comprehensive and detailed set of notes and comments on the data. This may mean that some parts of the data which are richer in detail have more commentary. It is advised to stay close to the participants explicit meaning but

alongside this you may find interpretative noting helps understand how and why the participants has these concerns. This involves looking at language used, context of concerns and abstract concepts which can help you to make sense of the participants meaning in their account. Another key concept at this stage is to be concerned with language use, among the things the researcher could attend to include: pronouns; pauses; tone; degree of fluency; and metaphors.

Step 3: Developing emergent themes

In looking for emergent themes the researcher is given the task of reducing the volume of data whilst maintaining the complexity, in terms of mapping the interrelationships', connections, and patterns between exploratory notes. This involves a shift from working with the analytic notes rather than the transcript itself. The main task involves an attempt to produce a concise statement of what was important in the various comments attached to a price of transcript. Themes are usually expressed as phrases which speak to the psychological essence of the piece but are grounded in the conceptual.

Step 4: Searching for connections across emergent themes

This stage involves the researcher developing a chart or map of how they think the themes might fit together. Not all emergent themes may be incorporated at this stage

and can be disregarded. It is suggested connections could be made by typing all themes in chronological order in a list and moving themes to form clusters of related themes. It is also important to make notes about how this key stage of analysis was conducted.

Step 5: Moving to the next case

The next stage involves moving to the next participant's transcript or account and repeating the process. It is important to treat the next case on its own terms which may mean bracketing the themes arising from the first case whilst working on the second. It is an important skill in IPA in allowing new themes to emerge with each case.

Step 6: Looking for patterns across cases

The final stage involves looking for patterns across cases. This usually means laying out step 4 for each case and looking across them. What are the connections across cases? Which themes are most potent? The final result could be presented in a table of themes for the group, showing how themes are nested within super-ordinate themes.

Initial Noting

Interpretive Noting

life?

Jack – I couldn't get people to see my point of view, I worked in the military way that if something goes wrong you lift a phone call and you make a phone call and it's sorted but civis have these systems where you gotta make two or three phone calls and it's not active till you got the letter saying so, in the military you make the one phone call and you trust the system so that's got to be a big challenge, I'm dyslexic as well but (long pause) there was a great sense of team work in the military, someone would be with you or got your back, also you would rather die than let anything happen to one of your mates, that's the mentality, also to strangers. You automatically have that rust and empathy with people in the military and it's like a cool environment bit it's got to be a two way environment, if the people are not responding back then you leave it off, it's just such a good environment in the military. I came in for a meeting here on Friday and this was an anniversary of an incident that happened that I have a great deal of guilt about cos I wasn't there to help and I said to them at the meeting I might have to shoot off but will give in ten minutes see how I get on but the minute I got chatting to the lads I felt better, and that's how it is.

Int- Being around fellow veterans and feeling as a team?

Jack - Yeah, the minute you go you get people promising you there as good as team as the Military promise anything just so

Couldn't get people to see his point of view

Wanted to work in the military way

Trust the military system team work in the military

Have trust and empathy with people in the military

Good environment in the military

Feelin guilty as wasn't there to help

Got chatting and feel better

Difficulty adjusting to Civilian Way of being

Comparison to military (easier way)

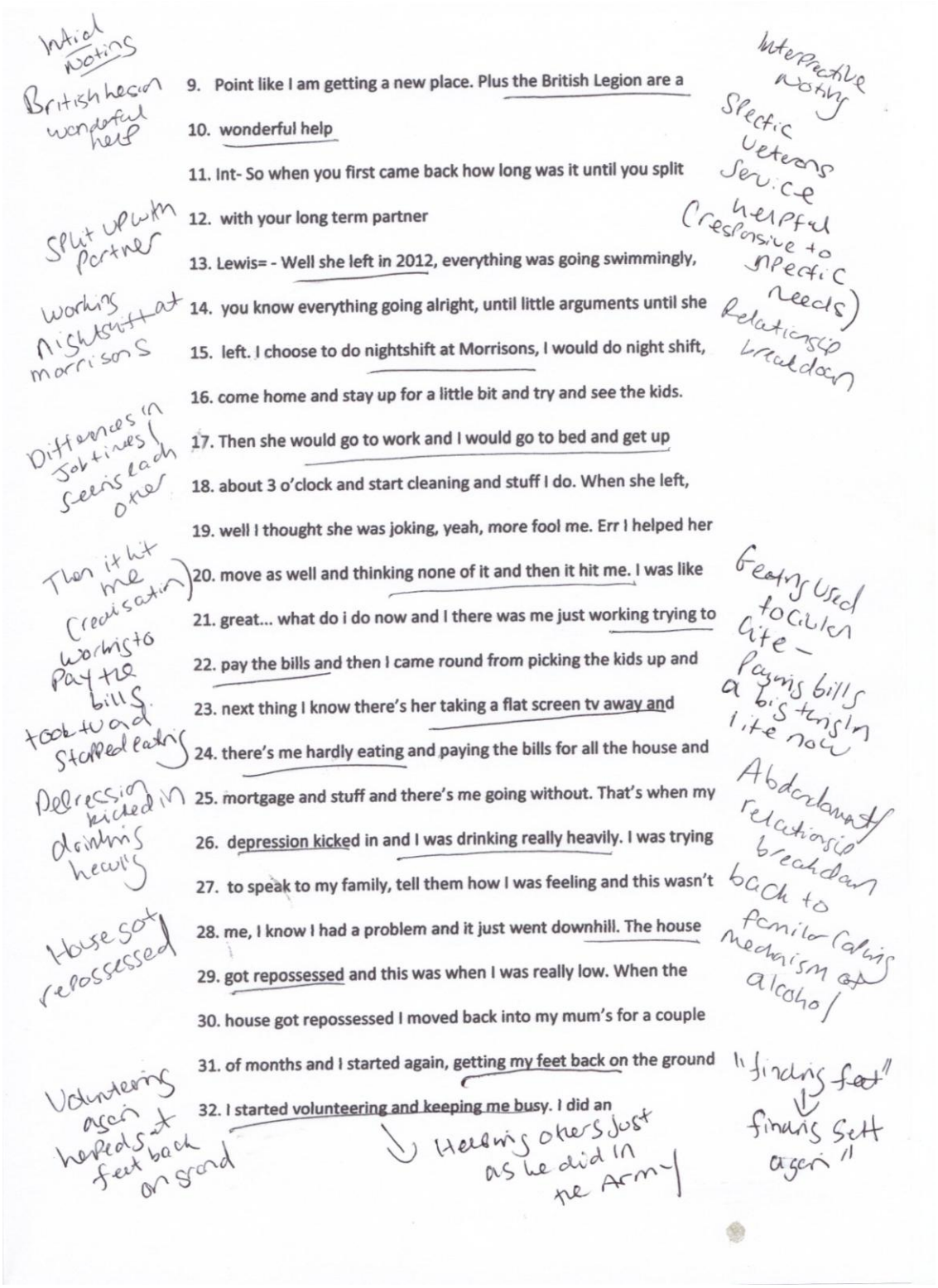
Teammentality Worked for him in the Army (absent in Civilian life)

Sense of loss Of this Military way of being

Good experiences of being in the Military

links with Other veterans

Sense of belonging again with people of Shared experiences


Intial Notins
British legion wonderful help
Split up with partner
Working nightshift at morrisons
Differences in Jobtimes/ seeing each other
Then it hit me (realisation) working to pay the bills took to and stopped eating
Depression kicked in drinking heavily
House got repossessed
Volunteering again helped get back on grond
9. Point like I am getting a new place. Plus the British Legion are a
10. wonderful help
11. Int- So when you first came back how long was it until you split
12. with your long term partner
13. Lewis= - Well she left in 2012, everything was going swimmingly,
14. you know everything going alright, until little arguments until she
15. left. I choose to do nightshift at Morrisons, I would do night shift,
16. come home and stay up for a little bit and try and see the kids.
17. Then she would go to work and I would go to bed and get up
18. about 3 o'clock and start cleaning and stuff I do. When she left,
19. well I thought she was joking, yeah, more fool me. Err I helped her
20. move as well and thinking none of it and then it hit me. I was like
21. great... what do i do now and I there was me just working trying to
22. pay the bills and then I came round from picking the kids up and
23. next thing I know there's her taking a flat screen tv away and
24. there's me hardly eating and paying the bills for all the house and
25. mortgage and stuff and there's me going without. That's when my
26. depression kicked in and I was drinking really heavily. I was trying
27. to speak to my family, tell them how I was feeling and this wasn't
28. me, I know I had a problem and it just went downhill. The house
29. got repossessed and this was when I was really low. When the
30. house got repossessed I moved back into my mum's for a couple
31. of months and I started again, getting my feet back on the ground
32. I started volunteering and keeping me busy. I did an
Helping others just as he did in the Army
Interactive noting
Specific Veterans Service helpful (responsive to specific needs)
Relationship breakdown
Eating used to cope with life - paying bills a big thing in life now
Abandonment/ relationship breakdown back to familiar calming mechanism of alcohol
"finding feet" finding self again"

APPENDIX K: Audit Trail of Results (Chapter Two)

Interview 1 – Paul

Super-Ordinate Themes	Main Themes	Emerging Findings/Themes	Line by Line Quotation	Line(s) Reference Number
Them and us.	Difficulty adjusting to practical civilian ways of life.	Difficulty adjusting to practical civilian ways of life.	At first mainly money worries and bills and rent to paid for... difficulty having to pay out for bills.	2-5
Them and us.	Them and us.	Realisation of social differences in Army, mentality and social life.	Can be a knob in the Army and get away with it, but cannot do that in civvy street, its different, people hold grudges	8-10
Abandonment.	Abandonment.	Abandonment from the Army.	One day in the Army, and the next I was out and had to get on with life.	17-19
Journey with alcohol.	Big drinking culture in the Army.	Drinking culture in the Army.	Drinking more than I should do, but it goes part and parcel with the army.	38-39
Journey with alcohol,	Alcohol negative influence on interpersonal relationships.	Difficulties with alcohol and interpersonal relationships.	Coming home from work to my girlfriend, and then drinking all the time which put a strain on things.	47-49
Them and us.	Civilian life has no structure and direction.	Lack of structure and direction/reliance on this in the army.	Difficulties in making a life.	58-59
A new identity away from the army.	Discovery of a new civilian life.	Finding one's self again.	Veterans contact point gave me that leg up.	60
The value of	Support	Support services	I was given structure	67

specific veterans support services.	services re-started my life again.	re-started my life again.	and direction again.	
The value of specific veterans support services.	Support services gave support in structure and direction.	Support services gave support in structure and direction.	I was made redundant and I went back to the drink.	69
Journey with alcohol.	Reliance on alcohol as a means of coping with stressors.	Reliance on familiar ways of coping.	My missus soon snapped me out of it sharpish.	74-75
The value of specific veterans support services.	Positive benefits of interpersonal relationships.	Positive benefits of interpersonal relationships.	Veterans contact point should be made nationwide.	76-77
The value of specific veterans support services.	Recognition and value of specific support services.	Recognition and value of support services.	Drinking was my way of coping, wasn't coping just existing and times were hard.	91
Journey with alcohol.	Difficulty with alcohol, it's hard coming out the Army.	Realisation of difficulty with alcohol and experience of it being hard coming out the military		107-108

Interview 2 – Lewis

Super-Ordinate Themes	Main Themes	Emerging Findings/Themes	Line by Line Quotation	Line (s) Reference Number
Negative impact on interpersonal relationships.	I am different in relationships now I have left the army.	Difficulty in relationships.	My missus left me and I got diagnosed as depressed.	3-4
Abandonment.	Abandonment.	Abandonment.	I didn't have any help.	4
Positive value of support.	Practical support valued.	Practical support valued.	Contact point helped me a lot and got me a new place.	8-9
Who am I as a veteran.	Difficulty adjusting to civilian working roles.	Difficulty adjusting to civilian working roles.	I had to keep doing the night shift and come home and see the kids but then had to go back to bed.	15-17
Reliance on alcohol.	Reliance on alcohol as coping mechanism/ breakdown of relationship.	Reliance on alcohol as coping mechanism/ breakdown of relationship.	That's when my depression kicked in and I was drinking heavily, paying the bills, and the next thing I knew she had taken the flat screen TV.	23-25
Who am I as a veteran.	Who am I as a veteran.	Who am I as a veteran, struggling with veteran identity.	I still class myself as young, I mean veterans are old like from the Falklands and Second World War.	38-41

Abandonment.	Value of team mentality, abandonment isolation.	Annoyance at lack of support.	In the military you got your mates and your muckers; there's nothing here, you don't get it anymore.	61-63
Them and us - civilians don't understand me.	No support in civilian world.	No one understands us.	Don't get no support, no nothing.	63
Them and us.	Them and us.	I am different.	You have to re-adjust and, well, you have been trained to kill and no one understands that.	64
Them and us – civilians don't understand me.	I am different from civilians.	I am different.	You go for a run and feel that people are staring at you.	69-70
Longing for the military.	Isolation/longing for military ways of being.	Longing for military ways of being.	It is extremely isolating, I miss all the banter.	74
Who am I as a veteran.	Struggling with independence.	Not knowing what to do with independence.	Its hard having control over all the finances again, especially when you want to drink a lot too.	81-82
Journey with alcohol.	Journey with alcohol.	Used to use alcohol.	I used to use alcohol.	100
Them and civilians don't understand me.	Civilians don't understand me.	Reflections on desperate times.	I was trying to tell people how I feel but no one was listening.	101-102

Them and civilians don't understand me.	Reflections on desperate times.	Reflections on desperate times.	I did try and end it all... three times.. I'm not happy about that, I think I was being selfish.	113-115
Who am I as a veteran.	I am proud of my army self.	Pride.	I was proud of what I did, I wanted to join the Army since I was little.	167-168
Using my Army skills.	Using structure and military ways of being to help.	Holding on to military traditions.	Cleanliness helped me, got to be immaculate when in the army, so I am a clean freak.	180-183
Shared identity in support service.	Re-creation of the army in the support service.	Shared identity of the veterans support service (equal) re-creation of military ways of being.	It's the banter-camaraderie, not looked down upon and I am treated like an equal... I love it.	197-198

Interview 3 – Bill

Super-Ordinate Themes	Main Themes	Emerging Findings/Themes	Line by Line Quotation	Line(s) Reference Number
I no longer have the safety of the army.	Army was my rescue.	Army was my rescue.	Well if it was not for the army, I would not be here today.	5
I no longer have the safety of the army.	I no longer have my protection of the army.	I no longer have my protection of the army.	I tried to commit suicide three times, not when in the army but since leaving the army.	18-19
I no longer have the safety of the army.	Army was secure.	Army was like family.	Your one big family in the Army.	40
Continuation of military ways of being.	Making connections to army life.	Connections with the army still apparent.	I have got friends who were in the army around here.	54
Continuation of military ways of being.	Team mentality important.	Likes team mentality.	I was making headrests, seat covers and bits of cars and we had a team working on it.	74-75
Civilians are different.	Civilian attitudes are different.	Civilians are different and their attitudes are different.	He said don't worry I will pay you back, but he never did. It's the attitudes of these people, you wouldn't have that in the army.	94-96
Continuation of military ways of being.	Making connections to the helping/supporting nature of the army.	Volunteering, helping others, similar to army mentality.	I've been volunteering, I enjoy it.	106

Civilians are different.	I am different to civilians in working roles.	I am different to civilians in working roles.	Couldn't get the jobs I wanted as they said I was too experienced or they don't need you.	113-114
I no longer have the safety of the army.	Feeling unprepared by the army for transition.	Feeling unprepared by the Army.	I don't think they prepare you, no they don't.	125
Negative emotional consequences of leaving the army.	The loss of the army activates sadness.	The loss of the army activating sadness.	I went straight down, went straight downhill in mood.	138
Negative emotional consequences of leaving the Army.	Feeling lost after leaving the army – grief reaction.	Feeling lost after leaving the army – grief reaction.	I didn't know what to do or what to expect.	139
Civilians are different.	I have tragic different experiences than civilians.	I have tragic different experiences than civilians.	I saw many of my friends die around me when I was in the Falklands.	171-172
The value of shared experience.	Re-creation of sense of belonging.	Religion helps.	When it's quiet I will check my e-mails looking for passages of the bible and use it in prayer – it's nice.	186-188
The value of shared experience.	Helping others is important.	Continuation of helping others.	I help everyone else rather than me.	207
Benefits of support services.	The value of the shared experience.	Importance of talking to others who have the same experiences.	Men like to talk to men in the army, at their level.	214-215

Civilians are different.	Feeling un-supported in civilian world.	Feeling un-supported.	Hell of a lot needs to be done to help us ex-service out.	240
Civilians are different.	We have unique skills.	We have unique skills.	All we do is get taught to kill.	243

Interview 4 – Jack

Super-Ordinate Themes	Main Themes	Emerging Findings/Themes	Line by Line Quotation	Line(s) Reference Number
I am not civilian.	There is no changing me.	I am a changed person.	They train you to be a military person but no training to put you back.	5
I am not civilian.	Can't turn being military off.	Continuation of a military way of being.	Always got a military head on you.	6
I am not civilian.	We are different in relationships.	We are different.	That is, we are in squaddie marriages... it may seem strange to people.	10
Staying connected.	Reliance on military ways of coping.	Reliance on military ways of coping.	My better half said she liked my humour, but I couldn't turn it off, even if something had gone badly wrong.	17-19
Civilian world is threatening.	Civilian world is perceived as threatening.	Civilian world is perceived as threatening.	Sense of threat never leaves you.	31-32
Civilian world is threatening.	Retreat from civilian threatening world.	Retreat from civilian threatening world.	Isolation very common among ex-service types.	37-38
I am lost without the army.	Isolation.	Isolation.	For a couple of years I didn't come out of the house.	42
I am not civilian.	Avoidance of work – it won't be the same.	Stayed away from work.	I tried not to work initially, stayed away from it.	81

Staying connected.	Trying to find self.	Feeling lost, trying to find self.	I just did a lot of walking everywhere.	100
I am lost without the army.	Lost direction in life.	Lost direction in life.	I thought that I was following a track but I turned back and there were tracks everywhere.	104
I am lost without the army.	Feeling lost with life.	Feeling lost.	I knew I was lost.	104
I am not civilian.	Frustration at not being heard.	Differences among army and civilians.	I couldn't get people to see my point of view.	109
Abandonment.	I trusted the army.	I trusted the army.	In the military you made a call and then you trust the system.	114
Staying connected.	Team mentality in the army.	Team mentality in the army.	Great sense of team work in the military.	116
Benefits of support services.	Veteran service re-captures what I am missing.	Veteran service recreates team mentality, gives me what I need – being around others with shared experiences.	I mean I came in one Friday, on the anniversary of an incident I have a lot of guilt about... thought I would have to leave the meeting early... but as soon as I got chatting to the lads, I felt better.	123-127
Civilian world is threatening.	Distrustful of civilians.	Distrustful of civilians.	They can stab you in the back and start counting favours.	133
Civilian world is threatening.	I am distrustful of civilians.	I am distrustful of civilians.	In civvy street it's just a bunch of lying back stabbing and thieving.	135-136

Civilian world is threatening.	Retreat to manage unsafe civilian environment.	Retreat to manage unsafe civilian environment.	They are all the same and you lack trust and before you know it your back behind the curtain.	142-143
Civilian world is threatening.	Distrustful of new environment.	Distrustful of new environment.	When I moved up to Coventry, I saw loads of white people and I didn't trust any of them, different environment.	156-158 160
Abandonment.	Grief/loss.	Grief.	Big piece of you ripped away and you are left with emptiness.	
I am lost without the army.	Loss of belonging.	Lost sense of belonging.	One minute you belong to something and next your an ex.	163
Abandonment.	Abandonment.	Abandonment.	It's like you're gone out the door and that's it.	168-169
I am not civilian.	I am not civilian.	I am not civilian.	It's a new challenge, I'm a free man, I'm a civvy, it's all rubbish.	179-180
I am not civilian.	I do not fit in with being a civilian.	I am not civilian.	I am more not happy than ever, I hate being civvy, I can't do it.	185
Alcohol journey.	Alcohol journey.	Alcohol journey.	I don't touch alcohol anymore, I am too old for that now.	189-190
Staying connected.	Re-creation of helping others.	Helping others is important.	I started to volunteer.	203

Staying connected.	Making links with a military environment-can't let it go.	Re-creating army environment.	I helped at sea cadets and army and I was back in the military environment.	214-215
Helping others is important to who I am.	Helping others.	I wanted to carry on helping others.	I wanted a decent job and went into social work but it was very behavioural.	227-230
I am not civilian.	I feel let down by civilians.	I feel let down by new society.	I keep losing faith in civilian society things.	233-234
Staying connected.	Veteran service created sense of purpose.	Veteran service created sense of purpose.	I had purpose again, getting up every day.	278
Staying connected.	Veterans service re-created military environment	Veterans service re-created military environment	Had a reason to iron shirts again an help each other out, essentially a military environment	279-280
Helping others is important to who I am.	Helping others important to who I am.	Helping others important to who I am.	I'm helping people that really matters.	285
I am a team player.	I am a team player and always will be.	I am a team player and always will be.	I will do it for other people but not for me.	302
Civilian world is threatening.	It's hard to ask for help.	Recognition of difficulty asking for help.	There is squaddie pride.	346

Interview 5 – James

Super-Ordinate Themes	Main Themes	Emerging Findings/Themes	Line by Line Quotation	Line(s) Reference Number
Starting over.	My life was the army.	My life was all within the army.	My friends, family, my network was all within the barracks.	9
Starting over.	I am daunted by a civilian world.	Feelings of being daunted in new environment.	Trying to adjust to a new environment is very daunting.	11
Abandonment by the army.	Abandonment by the army.	Lack of support in civilian world.	You don't get any assistance or support, like you used to do in the army.	11-12
Abandonment by the army.	Abandonment by the army.	Feelings of being thrown away.	Once you leave it's like you are a mango and you are the good part and then the bad part is just thrown away.	13-14
Them/us (civilians are different).	Civilian life is alien to what I am used to.	Having to understand new systems.	Coming into the environment and trying to understand the system.	16
Benefits of early preparation.	Pro-active leaving planning.	Early leaving planning.	I moved my family into civilian society 5yrs before I left the Army barracks.	24
Benefits of early preparation.	Early planning has positive integration benefits.	The benefits of early planning.	I am now realising this was a wise move, I found myself in a good neighbourhood and good community.	29-30
Them and us (civilians are different).	Them and us (civilians are different).	Civilian world is bust and different from the Army.	What I have found in the civilian world, is that everyone is busy and out for themselves and the system plays you around.	38-29

I have unique skills.	Unique skills.	I am different from civilian people.	My profession is not comparable, or on the same level as civilian people.	45-46
Them and us (civilians are different).	Lack of enjoyment in civilian life as opposed to being in the army.	Lack of enjoyment in civilian life as opposed to the army.	It is not as enjoyable as what I am used to.	49-50

Interview 6 – Tom

Super-Ordinate Theme	Main Theme	Emerging Findings/ Themes	Line by Line Quotations	Line(s) Reference Number
Negative emotional consequences.	Disbelief and confusion in first transition.	Disbelief and confusion in first transition.	Obviously, sometimes 3 or 4 weeks so it just felt like I was on leave to begin with.	6
Personal qualities that have helped in transition.	Benefits of early preparation.	Early preparation.	I knew I was getting out, I had kind of looked into stuff.. I had sorted out a job... I had done a plumbing course on the latter stages before I came out the army.	8-10
Them and us.	Annoyance of civilian ways of working.	Annoyance at civilian ways of working.	I rang up to make sure I still had the job and they said No... .and it was like... so this is how they treat you in civilian life.	14-15
Team mentality cannot be re-created.	Team mentality doesn't exist in civilian life.	Team mentality/reliance on others not existing in civilian life.	I mean I was used to people looking after me.	19-20
Abandonment.	I am on my own now.	I am on my own now.	Case of realising: "oh, you're on your own now".	21
Abandonment.	It's like leaving family.	Leaving secure attachment, army like family.	Obviously, civilians all over the world have been looking after themselves all day, every day and all the time but for ourselves it's like... (long pause) it's like leaving home.	22-23

I have unique skills.	My unique skills are not recognised in civilian world.	Skills not recognised outside of the army.	Not through army qualifications, and through any of the qualifications I gained.	28
Creating a new identity.	Finding a new self.	Finding a new self.	Right, so I am not a plumber, got to sort out what the hell I am doing.	34-35
Personal qualities that have helped in transition.	Personal quality of work ethic helps in transition.	Work ethic has helped me in civilian world.	Because of your army background you're always going to have that work ethic... we're grafters.	42-44
Negative emotional consequences.	Disbelief/shock during transition.	Shock.	I mean the biggest thing for me was the shock, it was the shock factor.	62-63
Team mentality cannot be re-created.	Reflections on team mentality of the Army	Reflections on team mentality of the Army.	I mean it's more one-sided when you're in – you know the job would always get done.	80-82
Frustration at them/us.	Civilian world is missing out on unique army skills.	Still refer as "us", limited recognition of unique skills and annoyance at army.	But why waste a skill, and its costing the Army to recruit civvies in, while they are cutting people... I mean that's one of the things that hurts us and we're out.	95-99
Abandonment.	Army is like family ...can't recreate that in civilian life.	Army is like family and you can't recreate that in civilian life.	You never think it is family and you never experience it on a civilian job.	102-104
Team mentality of the army cannot be re-created.	Team mentality of the Army.	Team mentality of the army	Were gonna look after each other, no matter what.	107

Them and us.	Civvies don't understand us.	Lack of respect from civvies/lack of understanding of what we had to do.	I mean the usual question you get from civvies... Have you killed someone… I mean things like that... have some more respect.	116-117
Them and us.	We're unique.	Civvies don't know what it is like for us, we're unique.	Its life education... If you have been working in a factory for years then someone doesn't know or have insight... I don't think.	128-129
Creating a new identity.	Attempts to re-create army ways of being.	Attempts to re-create Army ways of being.	I think working in fitness I work with military and ex-military, so it re-creates that banter.	158-159
Creating a new identity.	Finding a new merged identity.	Finding a new merged identity.	It's the best of both worlds, don't have to go on tour but have the army still with you.	163-164
Them/us (civilian world is different).	The civilian world is different.	Unfamiliarity of the civilian world/ unprepared	I mean people say go to the doctors but where is the doctors and I don't even know where my records have gone.	175-177
Them/us (civilian world is different).	Army and civilian world do not compare.	Army and civilian world do not compare.	Doctors and hospitals and stuff like that. People just don't cover people's backs like we had in the army.	203-205

Them/us (civilian world is different).	Frustration at civilian legislation.	Frustration at civilian legislation.	I mean she needed to go through loads of health and safety questions, I was like seriously... I am putting my friend in the car and taking her to the hospital myself.	232-235
Frustration at them/us.	Frustration at them/us.	Frustration at them/us.	Where is the “get up and go”? No one has common sense to sort this out.	241-242
Continuation of military life.	Fight/flight still activated in civilian life.	Use of “we” language and reference to fight/flight response.	“We all get in fights”, “we use our fists” and “we use our feet”.	254
Frustration at them/us.	I am unique – why does no one recognise this.	Lack of recognition from civvy employers.	I mean I didn’t expect them to treat me special but they treat you just like some 18 year old with no experience.	260
Creating a new identity.	Finding a new self.	Lack of direction/finding one’s self.	I mean my interests keep changing.	314
Journey with alcohol.	Journey with alcohol.	Changes in alcohol consumption.	I don’t drink now, drinking is not good and I ended up getting hospitalised in Cyprus.	323-324
Personal qualities that have helped in transition.	Positive interpersonal influences.	Positive interpersonal influences.	My wife does not drink, so we have no booze in the house.	325
Journey with alcohol.	Journey with alcohol.	Doesn’t feel the need to drink alcohol now.	It doesn’t float my boat anymore.	327

Negative emotional consequences.	Feelings of guilt.	Feelings of guilt.	Do feel really guilty about not being there for people anymore.	352
Cant re-create team mentality of the army.	Cant re-create team mentality of the army.	Cant re-create team mentality of the army.	Lots of squaddies join the police or fire service, so you can recreate that feeling again but it's not the same.	355-356
Them/us.	Them/us.	Lack of understanding about individualistic civilian society.	Why would you not look after each other.	364
Personal qualities that have helped in transition.	I am a team player.	I am a helper and like to rescue.	Seeing people being let down, when I think they could be easily fixed and helped.	392-393
Creating a new identity.	Learning ways of working as a civilian.	Learning ways of working as a civilian.	It takes a long time for a squaddie to realise to go to ask for someone to help.	423
Creating a new identity.	New ways of being in a civilian society.	New ways of being in a civilian society.	I didn't know about the mortgage process but I went out and found out about it.	434
Journey with alcohol.	Using traditional methods of coping such as alcohol.	Reliance on alcohol. Retreat back to basic needs.	I can see why squaddies live on the streets as its like it is back to the simple things again, and then it's just booze as that's what they are used to.	483-486
Negative emotional consequences.	Feelings of guilt.	Guilt.	Yeah when the riots were kicking off in Birmingham I felt guilty I wasn't there to help.	547

Interview 7 – Hank

Super-Ordinate Themes	Main Theme	Emerging Findings/ Themes	Line by Line Quotation	Line(s) Reference Number
Starting over.	Daily living adjustment problematic.	Daily living things problematic.	I was based in Germany so when I left I didn't even have a bank account.	3-5
Abandonment from the army.	Abandonment from the army.	Annoyance at lack of support from the army.	Army didn't provide any accommodation, didn't provide anywhere to live.	10-11
Starting over.	I have gone back in time since leaving the army.	I have gone back in time.	At the age of 25, I had to move back in with my mum and that was not a good experience.	11-12
Starting over.	Starting again is a challenge.	Life after the army is a challenge.	I was having to sleep in my car for six weeks.	15-16
Value of shared experiences.	Valued support from specific veteran support services.	Valued support from specific veteran support services.	SAFA helped me out, grateful.	20
Starting over	Portrayal of strong image has been shaken in transition.	I don't talk about embarrassing experiences.	Embarrassing really... don't like to talk about it much.	21
Negative emotional consequences.	Feelings of embarrassment.	Feelings of embarrassment.	Spending time in my car all the time, trying to hold down jobs, nowhere to go, an embarrassment it was.	30-33

Abandonment from the army.	Abandonment from the army.	Had to deal with things on your own.	Army not really interested, not their problem anymore and you have to deal with things on your own.	37
Holding on to a military way of life.	I have things to show from my Army life.	Proud of military life.	I was proud of my qualifications, got a diploma in nutrition and it's was not a waste of time.	49-50
It's never like being in the Army.	Cant re-create army family.	Army like family.	Army was a brotherhood, nothing like it anywhere else.	53
It's never like being in the Army.	Civilians are different.	Civilians are different.	Can't get it with civvies, but I have an army mate and we still got that squaddie manor.	55
Journey with alcohol.	It was okay to use alcohol in the army.	Drinking culture of the army.	There was a lot of alcohol around... especially in the army… big, big drinking culture.	57-58
Journey with alcohol.	Journey with alcohol.	Drinking journey.	Used to drink really heavily at first but not so much now.	64
Negative emotional consequences (sadness/grief).	Sadness/grief.	Feelings of sadness.	I remember when I was on holiday and I just burst into tears, right dick I was, but I just cried.	69
Negative emotional consequences.	Feelings of guilt.	Feelings of guilt.	I also cried for all those that had died and I just felt so guilty.	74-75
Holding on to military way of being.	Continued activation of fight/flight response.	Continued activation of fight/flight response. Still in the army?	Really didn't sleep well at all... just couldn't switch off and I was always awake.	89

Holding on to military way of being.	Never let go of being in the Army.	Sense of danger never leaves.	Always on the lookout and I let people go in front of me.	91-92
Holding on to military way of being.	Work ethic is a personal quality I value.	Working hard is important.	I mean work, at one point had three jobs at the same time.	104
Holding on to military way of being.	Holding on to army way of life.	Holding on to army way of life.	I like my fitness and I used to do it a lot in the army.	115
Value of shared experience.	Value of shared experience in specific veteran support services.	Value of shared experience in specific veteran support services.	These organisations are designed for these people, they know where you are coming from.	142-144

Interview 8 – John

Super-Ordinate Theme	Main Theme	Emerging Findings/ Themes	Line by Line Quotation	Line(s) Reference Number
I am different from civilians.	I am a person entering a different civilian world.	Coming out was an alien experience.	It was a very alien and traumatic experience.	4
I am different from civilians.	Them/us.	Difficulty understanding civilian attitudes.	It was the civvies attitudes.	6
Holding on to life in the army.	Expectation life is going to the same as in the army.	Expectation life is going to the same as in the army.	Couldn't understand why people didn't look after each other and just themselves.	8-9
I am different from civilians.	I am different, I work hard compared to civilians.	I am different, I work hard compared to civilians.	Civvies lack respect and don't have the work ethic to work hard.	10
Who am I now?	I'm having to start over.	Starting over again/loss.	I went from being a Sgt Major and came out to nothing.	12-13
No one understands me.	Annoyance at lack of recognition for my unique skills.	I have skills no one will recognise.	I had management skills recognised in the army, but not in civvy street.	19-20
No one understands me.	Isolation.	Isolation.	It adds to the isolation and feeling alone.	24
I am different from civilians.	Desperate to carry on with army skills.	Desperate to carry on with army skills.	I just wanted to use my management skills.	29

Holding on to life in the Army.	Used army skills in different ways.	Set up own business.	In the end, I used my money from the forces to set up my own business.	31-32
Abandonment.	Unprepared/ unsupported by the army.	Feeling unprepared by the army.	No preparation from the army in coming out.	39
No one understands me.	Retreat as a way of coping.	Retreating.	Socialisation really difficult, just stopped going out completely.	45
No one understands me.	I am better off by myself.	Civilian world is daunting and would rather be on my own.	I was withdrawn in my own little world.	48
No one understands me.	No one understands me.	No one understands me.	I had a wife but no one really understands what it is like and its very isolating.	51-52
I feel grief/ bereavement.	I feel grief/ bereavement.	Feelings of being bereaved.	Coming out the forces was like a bereavement.	56
I feel grief/ bereavement.	Loss of power and military rank.	Loss of power/rank.	I went from being a Sgt Major to nothing and joining the rest of the people.	57
Who am I now?	Army identity removed.	Army was a massive part of my life.	It leaves a massive gap in your life.	59
Abandonment.	Abandonment.	Feeling unsupported.	I didn't stay in contact with anyone, you don't get any help.	68

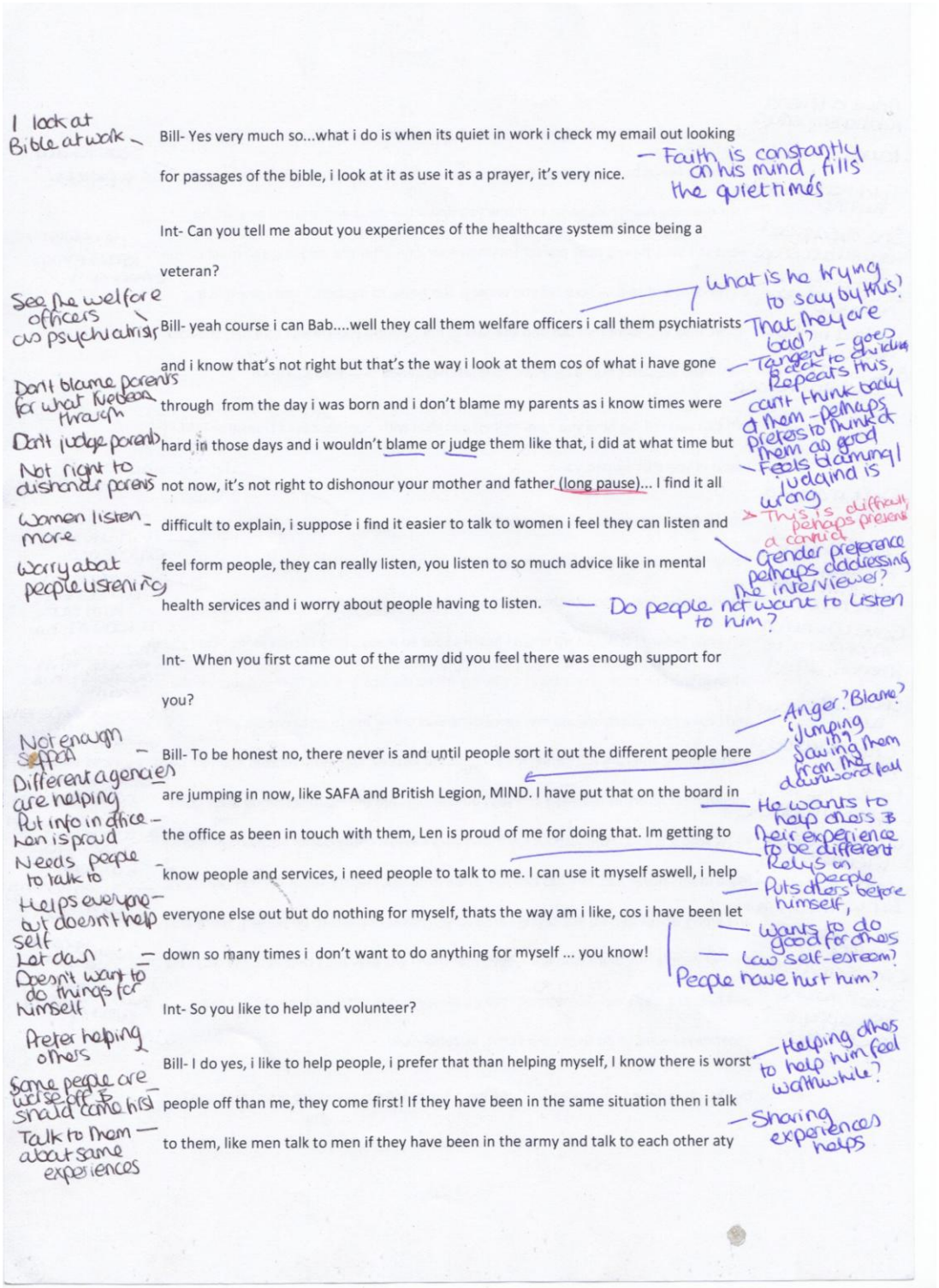
I am different from civilians.	Nothing compares to the army – cant recreate it.	Can never re-create that army feeling.	Nothing quite like being in the forces.	74
Who am I now?	Army was my identity.	Army was my identity.	It made me who I am and shaped how I live my life.	75
I am different from civilians.	I don't fit in with civilians.	I don't fit in with civilians.	It doesn't fit with civvy street.	75
Holding on to life in the army.	Military life/experiences never leave you.	Military life/experiences never leave you.	Sometimes its difficult just to turn off and you feel like you are still in that environment.	95-96
Holding on to life in the army.	Identification with team mentality of the army.	Identification with team mentality of the army.	Biggest problem ex-service personnel have is that they think about others before themselves... fight for the person next to you.	102-104
I am different from civilians.	I will do my way of doing things.	Civvies don't like the military way of doing things.	I joined the local bowling club but people thought I was taking over and didn't like it.	106-107
Holding on to life in the army.	Managing social situations with aggression.	Using fists/feet to manage difficult social situations.	I got drunk and attacked this guy, I just lost control.	108-109
Civilian world is threatening.	Civilian world is just as threatening as being in the army.	Fight/flight can't be turned off.	The fight/flight just cascades into civilian life.	115-116

Alcohol for coping.	Drinking was my coping mechanism.	Drinking as a coping mechanism.	I did admit to turning to drink when coming out.	127
Holding on to life in the army.	I am a hard worker.	I am a hard worker and will do things my way.	I couldn't abide by the way they got things done.	139
Benefits of support.	Family support important.	Family support important.	Having family around is most important.	159
I am different from civilians.	Civvies don't understand me.	Civvies don't understand me.	We need to get more people in the civvy world to understand.	180

Themes from the Interviews	**Sub-Ordinate**	**Super-Ordinate**
Abandonment.	Abandonment.	
No longer have the safety of the Army. Team mentality cannot be re-created. I am lost without the army. No one understands me. It's never like being in the army. Negative emotional consequences.	I have lost my Army family.	**The consequences of leaving the Army: "I am on my own now".**
Attempts to hold on to army life. Holding on to military way of being. Holding on to army life. I am a team player. Continuation of military ways of being. Staying Connected	Holding on to Army life.	**Them and Us.**
I am different from civilians. I am not civilian. Civilian world is different. Them/us. Civilians are different. Frustration at them/us.	Do I fit in?	
Journey with alcohol. Reliance on alcohol.	The use of alcohol: a journey.	**Surviving civilian life.**
Personal qualities that have helped. Helping others is important. I am a team player.	Personal qualities that have facilitated re-engagement.	

I have unique skills. Benefits of early preparation.		
Themes from the Interviews	**Sub-Ordinate**	**Super-Ordinate**
Benefits of support services. Positive value of support. Value of support services.	Structure and direction.	
Starting over. Who am I now. Creating a new identity. I am not a civilian. New identity.	Identity as a veteran.	**Constructing a new identity.**
The value of shared experiences. I am a team player.	Veteran's service provides a group identity.	

APPENDIX L: A Copy of the Analysed Transcript by a Fellow Qualitative Researcher for Creditability of Analysis Checks (Chapter Two)



Bill- Yes very much so...what i do is when its quiet in work i check my email out looking for passages of the bible, i look at it as use it as a prayer, it's very nice.

Int- Can you tell me about you experiences of the healthcare system since being a veteran?

Bill- yeah course i can Bab....well they call them welfare officers i call them psychiatrists and i know that's not right but that's the way i look at them cos of what i have gone through from the day i was born and i don't blame my parents as i know times were hard in those days and i wouldn't blame or judge them like that, i did at what time but not now, it's not right to dishonour your mother and father (long pause)... I find it all difficult to explain, i suppose i find it easier to talk to women i feel they can listen and feel form people, they can really listen, you listen to so much advice like in mental health services and i worry about people having to listen.

Int- When you first came out of the army did you feel there was enough support for you?

Bill- To be honest no, there never is and until people sort it out the different people here are jumping in now, like SAFA and British Legion, MIND. I have put that on the board in the office as been in touch with them, Len is proud of me for doing that. Im getting to know people and services, i need people to talk to me. I can use it myself aswell, i help everyone else out but do nothing for myself, thats the way am i like, cos i have been let down so many times i don't want to do anything for myself ... you know!

Int- So you like to help and volunteer?

Bill- I do yes, i like to help people, i prefer that than helping myself, I know there is worst people off than me, they come first! If they have been in the same situation then i talk to them, like men talk to men if they have been in the army and talk to each other aty

Themes

1. Who is he now?
2. Army offers parental role/attachment
3. Lost - Searching for something
4. Army as faith/religion
5. Army helps him cope
6. Impact of childhood led him here?
7. Helping others
8. People have treated him badly
9. Army has been good to him
10. Critical of army
11. Mental Health difficulties
12. Sense of lack of control/external influences/fate

Superordinate Themes

Identity - who is he, lost & searching for something
helping others, mental health difficulties

Army as Safety - army as parents/attachment, army helps him cope / army has been good to him, people outside army have treated him badly
~~Army as religion/faith~~

Locus of Control - Sense of lack of control/external influences/fate, Impact of childhood lead him here