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**Aspects of Defence: Discourse of Veterans,
Research Regarding Current UK Forces and Veterans
and Working Around Defence Mechanisms**

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**Portfolio Submitted in Fulfilment of DPsych Counselling Psychology
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May 2012

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Acknowledgements

To the participants who gave their time and words freely, without whom my research would be an empty page.

To my research supervisor, Dr Jacqui Farrants, for her unfailing questions and support which enabled me to start, continue and finish this thesis.

To the various tutors who have stood beside me in their encouragement to help me pass!

To my referees who believed in me in past years and enabled me to reach this point:
Gary Collins, Michael Lawson, Susanne Scott and Sue Vogel.

To my fabulous friends who have stuck by me as I have passed on this journey.

To my wonderful family, for all their support, encouragement and cajoling!

To CdePBS, for your love and unswerving belief that this would be completed.

Thank you to all.

LCV

Dedication

This research is dedicated to the memory of Leslie Smithhurst who fought till his last bullet in Calais, May 1940, was captured and remained a prisoner of war until 1945. For the immense stress that he experienced when fighting and incredible resilience he displayed in surviving internment. Sadly, he died before I could interview him for this research.

Preface

The current portfolio comprises three main sections which were compiled as part of a Professional Doctorate in Counselling Psychology at City University, London. The portfolio aims to examine aspects of the theory and practice of counselling psychology with a particular focus on the theme of defence in relation to veterans as well as defence of the self.

Sections of the Portfolio

Section A

Section A comprises the original empirical research which focuses on language used by UK veterans discussing stress and resilience. Their language is evaluated using discourse analysis and the resulting repertoires and discourse superstructure are discussed, particularly in relation to PTSD models and memory issues as well as applications in counselling psychology. In particular, the role of defence is investigated in relation to language used, especially from a performative perspective.

Section B

Section B comprises a critical literature review of recent research regarding current UK armed forces and veterans plus a small number of selected international studies. The review aims to explore the wide range of research available regarding these client groups whose occupation is or was connected with defence.

Section C

Section C comprises a clinical advanced process report in which I explore the integration of two apparently opposite counselling paradigms – cognitive behavioural therapy and the psychodynamic tradition – to work with a defence mechanism of a client. The original report is presented with later reflections encompassing further personal clinical and academic knowledge.

Themes Encompassing the Portfolio

Defence is the common thread entwining the three pieces of work within this portfolio. Defence as a construct can occur in a variety of ways and also at different levels of experience. That is, defence may occur at a national level with one country defending itself against another, whilst on a personal level, one might defend oneself against ones core beliefs of inadequacy through mechanisms built up over our lifetimes. On the one hand, one might need to defend oneself with a weapon, whilst another might defend against anxiety of mixing socially by retreating, or defend against a controlling person by employing a well-rehearsed defence mechanism.

Underpinning the core theme of defence are five areas of interest. In considering the portfolio, these five areas are like a propeller with five shafts, came to mind, with each area of interest, or theme, fanning the portfolio into existence. These five themes are illustrated in the following diagram:

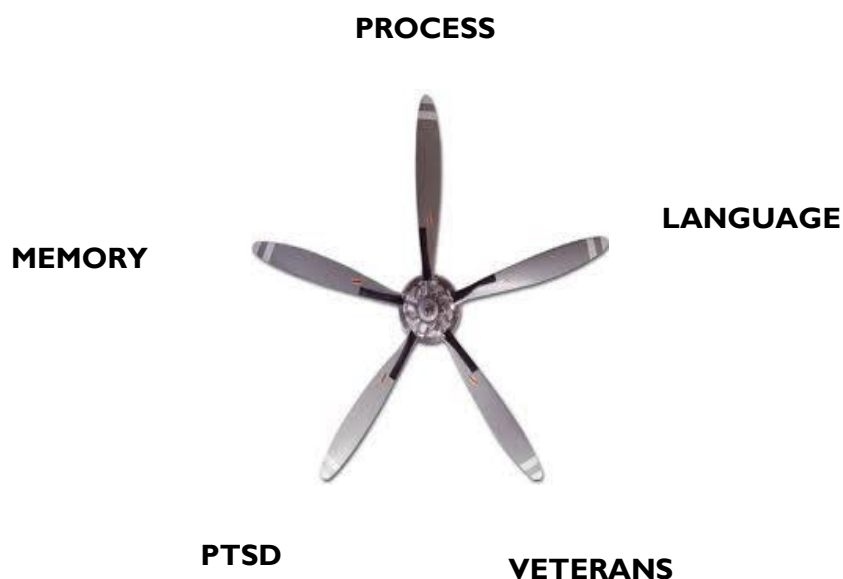


Figure 1 'Five Areas of Interest Propellor'

Starting at the top of the propeller lies process. Counselling psychology distinguishes itself from its near cousin of clinical psychology by placing emphasis on process and client-led work rather than the use of medical model-led sessions when working with clients. The word 'process' here signifies both what happens in the counselling room for the client, for the

psychologist and what happens between them, as well as the influence their outside lives have on the time they spend together. The counselling psychologist in training is taught through experiential sessions to recognise the importance of process in sessions. Recognition is then followed by learning how to utilise the occurrence of process in sessions in order to access a deeper level of understanding to the content of what a client is discussing. The use of process can help clients achieve greater awareness of themselves as well as inform the psychologists' own practice.

The practice of commenting on process is particularly evident in the advanced process report of the session I present where process was key to aid the unpacking of the client's defence mechanisms she employed against people she perceived held control over her. Process also underlines the practical suggestions for the repertoires discussed in the research paper. I was interested to see whether the psychologist might utilise the client's discourse as an indicator to discover processes occurring for the client and use these indicators in improving the client's self-knowledge, and also improve the therapeutic alliance via the clients' perception of the psychologists' understanding.

The next area of interest, fanning the portfolio into existence is language. As a race, humans rely on language as a main communication form to operate with each other. In the counselling room, it is no different. We rely greatly on language in psychology to work with clients; the modern terminology of 'talking therapies' indicates the importance language has for the occupation. From the early days of psychotherapy, the importance of language has been recognised. However, it is often the subject matter of a client's issues or their experience of them and therapy which is researched rather than language. This research seeks to draw the attention of the reader to language as an underutilised resource for the psychologist.

My interest in issues affecting veterans came about both through personal experience as well as through academic study and clinical practice. The difficulties faced by veterans known to me in seeking secure and confidential channels through which they might share problems they were experiencing led me to consider this group from a professional aspect. The occupational demands of being in the forces are unique and this is increasingly recognised by politicians, academics and practitioners. As well as considering process in the practice of counselling, my interest in veterans is particularly concerned with finding ways which might improve the therapeutic alliance through the basic tenets of counselling: empathy, congruence and positive regard. This portfolio, in particular the research and critical literature review, seeks to use the

mechanisms of language and knowledge of other research findings in order to strive to strengthen the therapeutic alliance.

Through the increased awareness of mental health issues affecting veterans, a deep passion for understanding more about post-traumatic stress disorder (PTSD) developed. There was much debate regarding the criteria of symptoms for PTSD as the Diagnostic and Statistical Manual produced by the American Psychological Association which has been published this year (2013). For the purposes of this portfolio, rather than becoming embroiled in the classification issues, the portfolio concentrates on how the presence of symptoms might be conveyed through language. Using Ehlers and Clark's 2000 cognitive model of PTSD provides a foundation on which to consider the repertoires discussed in the research as well as looking at how a discourse superstructure might be associated with PTSD. PTSD is also a common topic for consideration of the literature which was reviewed for Section C. Although it is recognised that not everyone who takes part in the Armed Forces and faces traumatic situations will develop PTSD, there is a raised prevalence rate over the national average for those who have experienced combat. This is reflected in the literature reviewed as well as other issues facing the armed forces and veterans.

The model described above uses a cognitive framework for PTSD which reflects my own practice and specialism of cognitive behavioural therapy (CBT) although at times I have also used person-centred and psychodynamic approaches in my clinical and academic work. The advanced process report in Section C indicates an opportunity I had to integrate both a CBT model of social anxiety in a client with addressing a psychodynamic construct of a defence mechanism that became apparent in the process of the session I write about. Blending the two approaches allowed me to address the defence mechanism as part of the process mechanism and the client was able to recognise an unhelpful behaviour and core belief which had developed since she was young. In addressing the defence mechanism (a psychodynamic construct) the client became more aware of how core beliefs (a CBT construct) were affecting her day to day life.

The final prong on the propeller points to memory. Through work with veterans, particularly those with symptoms of PTSD, issues with memory became more apparent. The research considers both information from neuropsychology as well as Brewin, Dalgleish and Joseph's 1996 dual representation theory in synthesising the results of the discourse analysis. This has been done in order to produce suggestions for how the research might be used by psychologists. Taking a practical view, I consider that to be a key point of research – that the

research might provide useful insight when working with veterans by considering how their language interacts with memory and may be a key to understanding their processing of stressful memories.

Bringing all these elements together has indeed propelled this portfolio into existence. There have been occasions where the topics I have been writing about have been mirrored in real life: experiencing stress and drawing upon resilience to complete the portfolio, being one example. Using discourse analysis has also given rise to a variety of experiences during the research process. One effect, evident in the thesis, is the focusing of attention on language and its potential impact on the receiver. The thesis is often written in a colloquial style, rather using scientific language, which might be more expected of a doctoral thesis. As I have struggled against being placed in an epistemological box, in favour of a more ethnographic approach, the language of this thesis resists the 'scientific' pull, instead positioning it in accessible terms.

The experience of producing this portfolio has certainly been varied, from excitement to despair, from ready production of language in written form to periods of writer's block, from stress to resilience. The process has required professional and personal resolve, reflecting the course of the counselling psychologist's journey and I hope this will continue for many years to come.

Section A Empirical research

The “D’s” in Defence: Interpreting Veterans’ Discourses of Stress and Resilience

Abstract

Veterans seeking psychological input for mental health issues, following service with the UK Armed Forces, report difficulties in relating to mental health practitioners, often causing them to disengage with therapy. A wealth of quantitative research including epidemiology studies and outcome reports is available for this client group as well as best practice of treating mental health issues including combat-related post-traumatic stress disorder. More qualitative studies are being produced, both for this client group and their associated mental health issues. However, there appears to be a paucity of qualitative literature regarding the language of veterans and it is this, especially in terms of improving the psychologists' understanding of this client group, which has inspired this research.

Nine veterans were interviewed using a semi-structured schedule and the data was transcribed and analysed using discourse analysis.

Nineteen repertoires are described within five groups: Professional/Objective; Personal/Subjective; Exclusive: Mind-Body Connection: and Refutation. In addition, one discourse superstructure – Defence – is identified.

Synthesis of the repertoires and superstructure takes place in relation to: military culture; masculinity; Ehlers and Clarks 2000 cognitive model of PTSD and DSM IV symptom criteria; and, neuro-psychology of memory and Brewin, Dalgleish and Joseph's 1996 Dual Representation Theory of PTSD. In addition, applications of the repertoires for counselling are suggested.

Statement of Intent

This thesis is not based on 'truths' but I stand by it as being a true presentation of my interpretations of the discourses between myself and veterans. By this statement, I am positioning myself as a social-constructionist, in analysing the way the veterans, my co-producees, talk about stress and resilience. As you read this thesis, I will seek to explain my position and findings in order that both you and I might be persuaded to consider enhanced ways of hearing veterans speaking in counselling rooms in the UK.

As this thesis is concerned with the construction of language, I believe it is pertinent to explain some of my discourse structures and terminology. I refer to myself as a psychologist (recognising that I am a counselling psychologist in training) who provides counselling although here are many terms used by professionals in similar roles such as counsellors, therapists, psychotherapists who offer talking therapies, therapy and so on.

In addition, as I am female by gender, the language I use within the thesis will reflect this; however, in doing so, I do not mean to exclude my male readers and do not imply in theory or practice a bias towards one gender over another.

I Introduction

Since the Vietnam and 1982 Lebanon wars, there has been an increasing amount of research into issues regarding the people who serve in the armed forces around the world, and the effects of combat and trauma on those personnel, both at the time of serving and in the years after. The research is wide ranging, and is being completed from a variety of disciplines including psychologists, medical doctors, psychiatrists, military advisors and neuro-scientists from many different countries including the United Kingdom, America, Israel, Australia, Canada and various European countries.

The range of research is prodigious: some is concerned with the epidemiology of mental health issues faced by these client groups including substance abuse, anxiety, depression, anger, aggression towards others, self-harm and post-traumatic stress disorder (PTSD) (e.g. Iversen, van Staden, Hacker Hughes et al., 2009). Some (e.g. Iversen, Fear, Ehlers et al., 2008) is concerned with protective factors, indicating who might be more likely to be susceptible to issues such as those listed above. Other research has been conducted into different treatments for these issues, in particular with respect to PTSD (e.g. Bisson, Ehlers, Mathews et al., 2007).

Continuing this theme, research is conducted into issues such as what it is like to fire a weapon with such accuracy, that you know when you have killed another human (Maguen, Lucenko, Reger et al., 2010) and the effectiveness of briefing and debriefing before and after tours of duty in combat zones (e.g. Sharply, Fear, Greenberg et al., 2008; and Adler, Litz, Castro et al., 2008).

The premise of this thesis is the psychological treatment of veterans (the term “veteran” is defined and discussed in Section I.I below). More specifically, this research is concerned with how the psychologist working with a veteran can use language as an extra resource in the counselling room. We have books and papers detailing treatments for people suffering with the after effects of trauma, such as the classics by Foa, Keane and Friedman (Eds.) (2000) and Wilson, Friedman and Lindy (Eds.) (2004). In addition, there are useful books such as that by van der Kolk, McFarlane and Weisaeth (Eds.) (2007) which provide more information in understanding the mechanics of trauma and symptoms and treatment of the traumatised to be considered.

To use a metaphor to illustrate these types of resources, I liken treatment books to a satellite navigation (sat nav) aide used by many people nowadays to help them get to a destination when driving in a car. One puts in a starting location and a final destination and the sat nav devises how to get from A to B in simple terms; the treatment books give instruction on how to treat people with mental health issues following trauma, often recommending a set pattern of treatment.

If the treatment of people following these instructions were straight forward, we would need no further books or research papers with suggestions on how to work with these clients. In reality, the psychologist sitting with a veteran in the counselling room will rely on more than knowledge of how treatment plans are put together for their client. This thesis is concerned with contributing to the psychologists' skills in order to work with their client. To carry on the sat nav metaphor, it is as if the psychologist is to act as a co-navigator with their client firmly in the driving seat, rather than using a sat nav system. As well as knowing how to plan the route from A to B, from traumatised to overcoming the effects of trauma, the co-navigator will draw on additional information which has been found to be important to improve the 'journey'. The psychologist will draw on important issues such as compassion, written about by Gilbert (2010), and the role of guilt and shame in PTSD as modelled by Lee, Scragg and Turner (2001). There is also great emphasis on the connection between mind and body where trauma has occurred, and again a classic resource for this is Rothschild's 2000 "The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment".

Alongside issues such as compassion and the mind-body connections to trauma, this thesis argues for the importance of understanding **how** clients speak in the counselling room when describing issues they have faced which still cause problems for them. In particular, the research is concerned with the language of veterans with a range of mental health issues and how to understand them better so that, as the co-navigator, the psychologist has an additional resource available to them to help their client along the journey.

In order to appreciate the particular problems of the language of veterans, it is necessary to explore a number of topic relating to the military:

- Contextual topics relating to UK Veterans
 - The Military Covenant
 - Veterans Mental Health Issues

- Military Culture and Stigma of Mental Health Issues
- Experience of Mental Health Services including provision
- Issues with Engagement in Counselling

- Research areas relevant to UK military personnel and veterans including
 - Stress and Resilience (including Hull (2002))
 - PTSD (including Ehlers and Clarks' 2000 Model of PTSD)
 - Memory Processing during and after Trauma (including Brewin, Dalgleish and Joseph's 1996 Dual Representation Theory of PTSD as well as Brewin's 2001 essay – "A cognitive neuroscience account of PTSD and its treatment")

- The Importance of Language and Discourse including
 - Counselling Psychology and the Research Topic

- An examination of the epistemological position of the thesis including
 - Journey towards Discourse Analysis and Social Constructionism
 - Deconstructing, Analysis of Discourse and Discourse Analysis

The final section of this introduction will be concerned with:

- The Development of the Research Proposal
- Aims of Research
- Reflexivity

1.1 Contextual topics relating to UK Veterans

The definition of a UK veteran, for the purposes of this research, is any person who has served for at least one day in the UK armed forces (the Royal Navy, the Army and the Royal Air Force) and has subsequently left. Dandeker et al. (2006) put forward the position that 'veterans' should also include the spouses and dependants of those who have served, as well as including those who served in the Merchant Navy. These additional people were not considered for the purpose of this research. There is also discussion about whether the term 'veteran' should be applied to those who have not been actively involved in a conflict situation, Since all who joined the three services are assumed to have been prepared, by joining up, to enter into combat situations, they will all be referred to as 'veterans'.

1.1.1 The Military Covenant

The UK veteran has been promised a special relationship with the UK government through the introduction of “The Military Covenant”. In April 2010, Andrew Murrison, MP, released the document called “Fighting Fit” (Murrison, 2010) which encapsulated the military covenant to all current UK armed forces and veterans. The covenant underpins the government’s commitment to providing veterans and servicemen with the best possible mental health care provision whilst serving and on retirement. Also included is the commitment to coordinating services so that access is optimised and provision of services is considered the best possible. The covenant draws out the need for four main improvements to support veterans:

- screening research;
- an increase in mental health practitioners working specifically for veterans and servicemen;
- a tracing service to follow up veterans within twelve months of leaving the forces;
- the introduction of an “early intervention service” (Murrison, 2010, p.1) which would be accessible online.

1.1.2 Veterans’ Mental Health Issues

It is well documented that once people have fought in a combat situation, there is a raised incidence of mental health issues that can be experienced (Rona et al., 2006). In Rona et al.’s 2007 study of UK current armed forces, the researchers were attempting to see if screening of troops before deployment to a combat situation might prevent psychological conditions. In fact, the research showed a low predictability for most common mental health issues except for PTSD although this occurred in relatively low numbers in itself, which the researchers believed did not merit the use of pre-screening. In a report in 2005, Rona et al. discussed the need for improved confidentiality of medical services in order to improve servicemen’s reporting of mental health issues as well as “improving support structures for servicemen and veterans” (Rona et al., 2005, p. 1260). These issues do not cease once the person had left the services and become a veteran.

In order to progress with suitable research ideas, a literature review regarding UK veterans’ mental health issues was conducted and the review falls broadly into the following categories:

- research on current British forces;

- research regarding foreign forces;
- issues facing veterans;
- research regarding stress and resilience; and,
- information regarding the British military.

With regards to literature that is available regarding the British military, much of the published literature is quantitative in nature. For example, a study by Gould, Sharpley and Greenberg (2008) quantifies the types of mental health services used by current service personnel. Within this report, they pointed out that a major objective of Ministry of Defence (MOD) services available through the MOD is to return the user to occupational fitness. The emphasis on the quantitative aspects of treatment in this paper and others relating to the British military appeared to ignore possible qualitative aspects of mental health issues within the military which might be of use in a therapeutic setting. Data collected was concerned with information such as service details, referral sources, treatment received, presenting problems and occupational functioning. By solely concentrating on the quantifiable aspects of mental health provision within the services, the report was useful in terms of providing numeric data, but omitted qualitative information which may be useful to a practitioner working in the mental health services and therefore useful for the therapy in resolving issues and maintaining mental well-being.

Hull et al. (2003) found that outward expressions of anger were correlated with depression and PTSD in UK armed forces, although it was noted that the anger could both be “healthy” as well as “unhealthy” (Hull et al., 2003, p.1222) which would either act to provide a functional release of the anger or otherwise, produce difficulties.

1.1.3 Military Culture and Stigma of Mental Health Issues

Rona et al. (2004) studied a large sample of current UK forces, concerned with screening troops for mental health issues. In their conclusions, they considered how some servicemen would not want to divulge information to a medical doctor due to a lack of trust.

Furthermore, those with a potential mental health issue may have been avoidant of medical services whilst those who were due to be deployed in the near future were unlikely to want to be screened for mental health issues (Rona et al., 2004 p.151).

With regards to information on the mental health of people who serve or have served in the military, the researcher has noted that members of the armed forces are less likely to report

mental health issues (Hoge et al., 2004). In addition, once someone has left service, mental health support is sought an average 13 years after leaving service (Southwick, 2008). In a case study of an ex-service person, Bryant-Jefferies (2005) noted that his client was loathe to talk to civilians about his combat-related experiences. Ormerod (2008) goes further by quoting a client of hers: “you could tell by the way he (his doctor) looked at me when I started talking about Iraq, he didn’t understand. I was wasting my time” (Ormerod, 2008, p3). This lack of understanding may be ameliorated by the resource which will hopefully evolve from this research project.

The researcher located one research paper which dealt with attitudes of service personnel serving in an overseas force (Inbar, Solomon, Spiro and Aviram, 1989). When presented with various vignettes of combat situations, Israeli Army commanders were asked about their attitudes towards the vignettes in terms of stress. It was found that the commanders were more tolerant of stress in their troops when the vignette included “high battle skills, physical injury, low rank or depressive symptoms” (Inbar et al., 1989, p215). In terms of the proposed research, it is posited by the researcher that she may find similar attitudes expressed in the language and attitudes in the interviews.

Finally, in a presentation at a Veterans Mental Health conference, Walter Busuttil, Medical Director of Combat Stress (previously mentioned) noted that a high number of service users of his veterans’ welfare service are non-commissioned officers – more than 95%. However, he noted that commissioned officers were also known to be suffering mental health issues related to their previous service experiences but were under-represented in the numbers accessing veteran’s mental health services (Busuttil, 2008, p1). The researcher has considered there may be differences between the language used by commissioned and non-commissioned participants which might point to possible reasons for this disparity in help-seeking behaviour.

1.1.4 Experience of Mental Health Services including provision

As the Ministry of Defence (MOD), the Department of Health (DoH), regional health care trusts and organisations working with veterans develop and improve the provision of mental health services for veterans, it is noted that there are a wealth of mental health professionals working with this client group in one-to-one and group settings.

An article by Bexson (2007) regarding the services offered by Combat Stress (the UK charity specifically dealing with ex-service personnel in terms of mental health) highlighted the

demands on the services offered. Bexson highlighted a waiting list of six months for new referrals to receive an initial psychological assessment. The article also quotes an ex-service personnel's experience of being placed in an NHS Group therapy session where he was told: "you can't talk about those things. You'll traumatised the other patients." (Bexson, 2007, p13) highlighting the difficulties facing this group of service users in trying to explain their particular occupational experiences.

Another important reason why the researcher believes a reference resource for civilian counsellors is of importance is that increasing numbers of veterans may access NHS services in coming years. Although there was a myth that purported statistics showed that more veterans committed suicide (n=300) following the Falklands war than were killed in action (n=258) (Ormerod, 2008), this misinformation caused concern prior to events commemorating the twenty-five year anniversary of the Falklands war in 2007. Professionals considered that the incorrect statistic along with the anniversary might have acted as a trigger leading to an increase in help being sought from those who were involved in the war, or even have led to an increased risk of suicide (Ormerod, 2008).

Further to this, there have been 10,000 troops involved in the Iraq theatre (ie conflict or war situation); of these, 2,000 have already sought help for psychological problems (Ormerod, 2008). As of 2008, it was known that 15-20,000 troops had taken part in the operations in Afghanistan. If similar figures were to report mental health issues, one might expect 3-4,000 service personnel seeking psychological input.

There are an increasing number of NHS specialist traumatic stress centres throughout the UK as well as charities such as Combat Stress and Help for Heroes, which receive funding from the Ministry of Defence (MOD) as well as from other sources including the NHS in recognition of the work they do instead of the NHS. The NHS traumatic stress services report that they are already facing long waiting lists (Ormerod, 2008) which may become more pressurised under restricted financial circumstances of the current economic times. Whilst some clients will be referred to these traumatic stress centres and charities, it is envisaged by the researcher that psychologists and trainees will be seeing more veterans in their counselling rooms, in GP practices, secondary care services and various private and charitable organisations specialising in helping ex-service personnel.

Finally, it is reported by the MOD (Gould, Sharpley, and Greenberg, 2008) and also by the UK legal and justice systems (Ormerod, 2008) that there has been an increase in incidences of

binge drinking, drink-driving, risky driving (high speed, etc) and personal violence both against people known to them and against strangers. These activities are thought to be indicative of self-medicating for stress. The researcher believes by improving counsellors' understanding of issues veterans face during their years of service, this may improve the efficacy of therapy for this group of people.

1.1.5 Issues with Engagement in Counselling

Counselling can be difficult for many clients. However, I posit that for the veteran sitting in a counselling room with a psychologist, the perception of lack of understanding of their occupation and its demands may have serious negative consequences even leading to the veteran disengaging in therapy.

One major reason for this research is various barriers have been recognised to be standing in the way of ex-service personnel in seeking treatment for mental health issues (Hotopf, Hull, Fear, Browne, Horn, Iversen, et al., 2006). Also, ex-service personnel who have sought treatment have commented that the civilian has little understanding of military life (Bryant-Jefferies, 2005). This lack of understanding undermines the client-therapist relationship and ex-service personnel report leaving counselling services early as they do not believe they are being understood (Ormerod, 2008).

1.2 Research areas relevant to UK military personnel and veterans

1.2.1 Stress and Resilience

When first proposing this research, I envisaged I would only use definitions of stress and resilience which were constructed by the interviewees. My fear was that I might be constrained by early definitions. I have made the assumption that, due to the nature of their employment in the forces, veterans would have experienced stress and would have to rely on resilience in order to carry out their jobs. At this point, in other studies, it would seem appropriate to define the constructs 'stress' and 'resilience'. As this research is concerned with listening to the producers of language (veterans) discussing these words, I will not introduce others' definitions for these constructs, but instead will consider research about the issues they present for this client group.

As technology improves, we are privileged to gain much greater information and understanding about the physiological effects of stress on the human body. Hull (2002) systematically reviewed literature relating to neuroimaging and PTSD and we now know how the brain adapts under stress structurally. In addition, we have greater information about the effects of neurotransmitters, which are produced in response to stress, such as adrenalin. In simple terms, this is produced in the liver and acts like a warning chemical for the body, readying it for the fight or flight reaction. Connected with this is cortisol, involved in the freeze reaction that will also occur at times of high stress. As the adrenalin is pumped around the body, there is increased blood flow to key organs in the body and muscles such as the heart, which will start to beat faster and the lungs which will operate quicker.

Whereas some areas of the body have increased blood flow to cope with the fight or flight response to stress, neuroimaging has shown that in parts of the brain there is a reduced blood flow, particularly the upper parts. The areas of specific note are the language zones around Broca's area and also the frontal cortex, which is associated with planning and behaviour. The reason for particularly drawing out this information is that, as there is less blood flow in these areas at high stress, they are operating sub-optimally. In particular, I am interested that this decreased processing in the area of the brain which is involved in language will affect how someone uses language, or rather may struggle to use language, when describing a situation of stress later. If the person lacked language skills at the time of the stress, part of the psychologist's role will be in helping the client to 'voice' the trauma – using language.

It is also of note that these neurotransmitters have further effects on other brain processes, particularly the creation of memory, which I will discuss in a short while when considering a model for memory processing and PTSD.

Coming away from the biomechanics of stress, Sudom, Dursun and Flemming (2006) considered vertical and horizontal cohesion within Canadian military units and found that greater cohesion was linked to moderating levels of operational stress. In addition, this effect was not only at unit level, but also impacted positively on individual morale. They also showed that those staff who employed high levels of active coping strategies displayed higher levels of personal morale. The implication from the results of the study was that the encouragement of cohesion within a unit would attenuate the effects of stress. In terms of the military and units, the researcher has considered that this cohesion may have positive effects such as sharing experiences of trauma, hence normalising and reducing stress. However, the researcher has considered that a drive towards cohesion may inhibit anyone who was trying to deal with

stress and lacked active, healthy coping styles, and may therefore be put off from seeking help as they may not want to be singled out. This is one of the reasons stated for not seeking help (Hoge, Castro, Messer, McGurk, Cotting and Koffman, 2004).

By including resilience as well as stress in the subject matter of my research, I was concerned with the trend noted by Lopez et al. (2006) who have highlighted counselling psychology's interest in positive psychology. Indeed, in their recommendations from their content analysis study, they point out that counselling psychologists should "develop or enhance a 'strengths vocabulary'" (Lopez et al., 2006, p.222).

With regards to resilience, Smith (2006) goes further to suggest that positive psychology can be used to categorise strength which itself plays a role for people with regards to emotional and character strength (Smith, 2006, p.29). There are many outcomes of this strength, including helping people to make sense of and tolerate difficult times. It seems to me that these descriptions are closely connected with resilience. Smith continues in her consideration of strength to research whether some situations inhibit the development of strength whilst others encourage the development of it. In considering the development of people's skills whilst in the forces, it could follow that the institution of the military is designed to improve people's strength skills over their careers. Smith saw that some outcomes of strength-enabling situations were that individuals had high self-esteem and self-efficacy and that strength also acted as a protective factor against risk or trauma (Smith, 2006, p. 31).

Ahmed (2007) considered the issues of post-traumatic stress disorder (PTSD) in relation to resilience and vulnerability. He highlighted various factors which could promote resilience such as self-esteem, having a sense of humour and religious affiliation. I will be interested to examine, through the discourse analysis of the interview transcripts, how the participants construct their language and if they talk about any of these resilience factors.

1.2.2 PTSD

We have seen above that armed forces and veterans, like the rest of the population, experience mental health issues with similar prevalence rates. However, as pointed out by Rona et al. (2008), once a person has been actively involved in combat, there is an increased risk that the person will go on to develop symptoms of PTSD, raising the prevalence rate from 3% to 7% (Rona et al., 2008). The criteria from the American Psychological Association (APA) Diagnostic and Statistical Manual fourth edition (DSM IV TR, 2000) (see Appendix A) were

under consideration with the next edition of the DSM published in May 2013. These enhanced criteria can be viewed in Appendix B. Although this thesis is not directly concerned with arguments regarding the different criteria, I recognise that the criteria play an important role in the diagnosis of PTSD in veterans and the subsequent consequences such as pension payments and treatment availability. In addition, when listening to a client recalling their experiences, I propose that there is a relationship between the language used and these criteria.

At this point, I want to consider PTSD from the mechanics of how it occurs and why the symptoms develop. To do this, I focus on the classic model, developed by Anke Ehlers and David M Clark in 2000, which uses a cognitive basis for explaining PTSD. The figure shown below is how they illustrated their model:

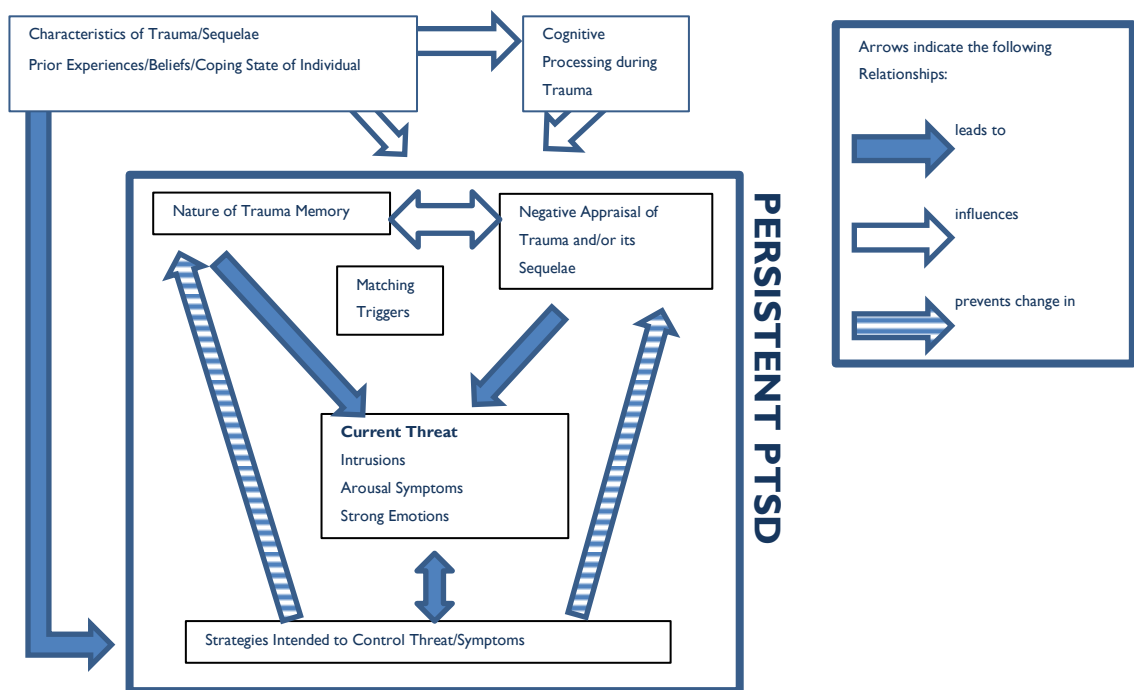


Figure 2 Ehlers and Clark, 2000, Cognitive Model of PTSD, p.321

If we consider this model in terms of the armed forces and veterans as well as in terms of discourse, by starting with the characteristics of the trauma and any sequelae, we see that possible occurrence of traumas and associated psychological after effects which might be linked to combat and peace-keeping duties such as face-to-face fighting, involvement with improvised explosive devices (IEDs) and patrolling combat areas. In these circumstances, the consequences are often considered as traumatic incidents in their own rights – dealing with the dead and injured – both colleagues as well as others, including enemies, as well as the grisly

task of clearing up human remains after such incidences, both in situ as well as cleaning vehicles used in transporting people, bodies and body parts. Prior experiences like training and tours of other combat zones will influence how someone reacts to trauma as well as the individuals' beliefs and coping mechanisms from both before service and during. In addition, the state of mind of the individual as they face the trauma will be important, and this is where training and briefings will play a role in how someone responds to traumatic and stressful events. As we have explored earlier, the military culture creates cohesive units, drawn to work together with an 'esprit de corps' necessary for optimising outcomes in dangerous situations.

I have already discussed cognitive processing in terms of some neurological responses to stress and trauma. I will continue this theme in the next section when I present the work of Brewin, Dalgleish and Joseph (1996) for consideration within the framework of this research. Ehlers and Clark assert that cognitive processing will be 'influenced' by the characteristics of the trauma as well as the person's prior experiences and beliefs and coping strategies. Both of these in turn influence the possibility of the person suffering from PTSD. In terms of this research, it will be interesting to see how far the veterans are aware of cognitive processes at the time of stress occurring. If they were not, I am interested to see how they then describe the situations and how the language they use might be influenced by this.

Within the 'box' of persistent PTSD, each of these conditions may be evident in language used when considering the trauma and/or sequelae. As discussed before, when describing a trauma memory, there may be some disruptions due to sub-optimal working of the language area during the trauma. An appraisal of the situation may contain many negatively-associated words or turns of phrase. As the person brings to mind the threat they previously faced, intrusive thoughts, images and sensory reminders may lead to the arousal of symptoms experienced at the time of the trauma and these may be repeated in the counselling room, disrupting speech and cognitive processing again. Even the strategies that the person tries to employ to reduce threat and symptom re-experiences may be audible in their language.

1.2.3 Memory Processing during and after Trauma

Having discussed memory processing from a neurological point of view as well as the effect, or influence it has in a cognitive model of PTSD, I was interested to see how it might be explained as a process in itself before, during and post a traumatic event. Having run a psycho-education group on memory for a charity working with veterans, I have seen first-hand the distress caused by changes in memory processing on a day to day basis, as well as the on-going effects

of disturbing trauma memories themselves. One of the most frequently asked questions was, 'do I have Alzheimer's because of the PTSD? I used to have such a good memory.' Because of this and other functional questions, I found it useful to have working knowledge of the neuroscience of memory in order to enhance their psycho-education.

In addition, as a psychologist working mainly from a cognitive behavioural paradigm, I have found it useful to consider a cognitive theory of memory processing for PTSD and want to particularly highlight it (Brewin et al., 1996) as well as Brewin's subsequent invited essay (Brewin, 2001) regarding the dual representation of memory. The theory considers verbally accessible memories and situationally accessible memories. In particular to this research, are the verbally accessible memories – a possible indication of how far through the processing of trauma memories someone is.

The theory considers three outcomes with regards to memory processing after a person has experienced trauma. The first is where the person has been able to work through all their memories completely and has been able to incorporate the information without them giving distress on recall. The person has been able to make adjustments to their self-view so that the actions and consequences are explicable. The authors predict someone who has achieved this level of processing of memory would not indicate a bias in their attention towards the incident or stimulants. The second level of processing outcome is described as 'chronic emotional processing' (Brewin, et al., 1996, p. 679) – an incomplete processing possibly due to the harshness and timing of the trauma. It is into this group that war veterans are thought as mostly likely to fall: the person is constantly considering potential threats and their evaluation of both the traumatic event and possible future ones is dire. The last outcome in terms of memory processing is known as premature inhibition of processing. In this category, the person rehearses ways to overcome memory and somatic responses to the trauma. Attentional bias, however, is high towards stimuli and this may be apparent in language. These three outcomes appear to have close links with whether someone has symptoms of PTSD and clients may present between the second two when accessing mental services.

1.3 The Importance of Language and Discourse

“you haven’t got the first fucking clue what I’m talking about”¹

The quote used above is from Richard Bryant-Jefferies’ book on counselling victims of warfare and comes from an account of a UK veteran who had seen active service overseas (Bryant-Jefferies, 2005). The veteran, who is struggling with the symptoms of PTSD, is faced with a psychologist who has not experienced what he has been through and he challenges the psychologist about this difference in experience. The quote comes from the imagined thought process of the veteran.

As a psychologist, I consider the language and discourse of the counselling room are central to working with a client – they are the key to unlocking how I get the “first fucking clue” of what a client is talking about? This was my starting point for my research and this resulting thesis. As I sit opposite a client in a counselling room and they vocalise their issues, I question what resources I could draw upon from my training and experience that will help me understand both the client’s situation and how best to work with them.

As I pondered the resource of language, I reflected on how, in the counselling room, I rely on language as a tool that goes back and forward between psychologist and client. Willig (2003) notes that in counselling, language is productive, used in order to produce an account of the person’s experiences in order for the psychologist to gain understanding. Moving this idea of production forward, it is not only a constructive tool for accounts of experiences, but also, as Burr (2003) argues, a construction of the person themselves through structure and meaning (2003, p. 34/5). As a person speaks, there is not a randomly assigned structure and meaning to the issues they speak about, but instead a reflection of their associations with society.

So we see that language is not random, but provides definition and, in addition, it is developed through contact with others in society, through the use of language in interactions. At the same time, whilst language is not random, it is also not concrete. It has the ability to change over time and also within different contexts. The banter of the non-commissioned officer in the First World War would have been different from those serving currently as would the language used with his colleagues in the bar at his barracks be different from the language he

¹ Bryant-Jefferies, 2005, p.111

used on exercise or in combat. From this we garner that language has no fixed usage or meaning.

The implications of this is that the language of those in the military will change over time and in different situations and the meanings given to linguistic constructs such as stress and resilience will be defined by each individual with no fixed meanings. The prevailing view of each construct will determine its definition and older views of constructs will be left behind.

I hypothesise that for those serving in the military, by denying stress as a construct, as it is seen as an unacceptable response to the work being undertaken, has implications on the way the veterans will speak of stress and resilience. I have considered that on leaving the forces, the ability to describe the constructs of stress and resilience, in personal terms, will be difficult for the veterans as the language development of the construct has been pushed out of the regular discourse repertoires – the unspoken subject – the elephant in the room – whilst they were serving.

As Burr points, as language builds, maintains and rejects the identity of the self (Burr, 2003, p. 43) I question whether, by analysing the discourse of veterans as they are questioned about stress and resilience, there can be a raising of consciousness of the evaluation these people give to these constructs and how this might show an influence in their lives. In particular, I consider that language and thought are inseparable and so to analyse the discourse of these people is, in a way, to analyse their thoughts. Although discourse is not about discovering attitudes or beliefs, the discourse used will reveal thoughts about these constructs.

If we carry through this view that discourse is a key to understanding thoughts, we might also usefully see how memory may be influencing the thoughts of the veterans as they speak – and as they do, that they indicate the social structures and practices within which they operated in the military, that is the culture of the military. From the previous section regarding memory and thought processing following trauma, I am interested to ‘hear’ how veterans describe trauma, to see how far their discourse might provide insight into their memory and level of processing of stressful incidents. By gauging how far an incident has been processed in a client’s thoughts might be useful for the psychologist in helping them to further process incidents so they have less of a negative impact on them.

In addition, I am particularly interested in the performative function of discourse – the intrapersonal as well as the interpersonal, the power and speaking turns and rights that occur,

the agency of the discourse. This will be relevant in terms of analysis of the discourse, where performance or the role taken on by the veteran is particularly examined.

1.3.1 Counselling Psychology and the Research Topic

Lopez et al. (2006) point out that the term “counselling psychologist” was developed after the Second World War by American veterans’ organisations that were providing counselling as distinct from other psychological services. I found this piece of information fascinating, as I had not realised how my research topic was connected with my chosen profession. I consider counselling psychology as a dialogue – based on lexical as well as non-lexical elements. There can be a strong emphasis on the lexical content for psychologist, not just in content, but also in motivation and performance. Dialogue between client and psychologist is important as it can be seen to underpin the development of their relationship. There is an understanding not just of the content but of the meaning the client is providing.

In order to investigate the research question “What can be understood by the way stress and resilience is spoken about by veterans which may provide useful insight for the counselling psychologist?” I have considered how this understanding might be employed in general in a counselling setting with a veteran in order to break down stigma barriers to seeking help. As described earlier, I am particularly interested in how any potential perceived lack of understanding by civilians from the point of view of the veteran of the particular demands of the occupation they were in may be ameliorated by knowledge of the language constructions other veterans use when discussing stress and resilience.

In my role as a counselling psychologist in training, I have come to realise the importance of understanding the various nuances of discourse as a major resource in the counselling room. In the tradition of counselling psychology, we are taught that the way words are spoken, the words chosen to express issues and particularly the interaction between the client and therapist, that is the process, is paramount to the relationship between the two and therefore an important factor in the outcome of therapy (eg Mearns and Cooper, 2005). Tracing the origins of the importance that language plays in counselling psychology, I have considered the influence that Sigmund Freud has had on developing the first talking therapy (McLeod, 2001). Without the development of the talking therapy, people would remain struggling internally with issues. In addition, an interesting study by Avdi (2008) considers the importance of language-based research in relation to improving the training and development of therapists in their client work. He sounds a note of caution however, that due to this area of research

being relatively new, the lack of cross-referencing between studies limits the knowledge base in practice.

Using my personal exploration of process from university classroom to experience the effects of recognising and acknowledging process in practice has helped to educate me as a researcher about the importance of discourse to any client group. This has encouraged me to consider a client's motivations, meanings, understandings and expressions. By considering just one part of this, the use of language, for this research, I am hoping to tease out the kind of processes that might be apparent in a counselling setting for the participants. Further to this is the assertion that discourse can be seen as a performance between actors in a scene - whether that is client and psychologist.

In interpreting discourse, there is the difference between naturally occurring discourse versus the discourse of semi-structured interviews. I shall discuss this issue in greater detail with regards to methodology in practice in the next section. For now, I shall make the comment that I have struggled with producing an epistemological position with regards to this, sometimes wanting to lean towards a more ethnographic position of collecting data – collection in the moment, in the real world – without the baggage of adopting an epistemological position from the outset, but rather allowing this to develop. This approach is considered by Jefferson and Huniche (2009) where field work takes the place of set formats such as semi-structured interviews in a bid to consider the person in their real settings and watching the person in practice rather than in a created setting. As I set out below, I shall explain how I dealt with this to come to a personal epistemological stance.

In considering counselling and discourse, I am inspired by Burr (1995) to consider “the person as a discourse user” (p.113); “the self as constructed in language” (p.125); and “subject positions in discourse” (p.140). We are all, by nature, swathed in language as it is a primary communication tool. However, there is no one way to be a discourse user, but rather each individual has the choice to use discourse to suit her own environment, situation, wishes and as such, as has been alluded to earlier, we can see ourselves as performers in discourse. The counselling room is no less of a performance space with the client bringing selected information, presented in a variety of ways for the effect they want to achieve on the psychologist. And the psychologist plays the role of audience, questioner, challenger and imparter of information, again, with a performative role of that of psychologist.

When considering “the self as constructed in language” (Burr, 2005, p.125) Burr highlights two approaches: firstly that we can construct ourselves through the “grammar of language” (Burr, 2005, p.125) and secondly through the stories, or narrative, that we produce about ourselves in relation to world. Initially I was interested to see if I could discover if there was a common language construction around the narrative of stress when asking veterans to talk about stress, based on some level of common experiences when serving. However, in preparing this research I became more interested in how the individuals demonstrate a construction of themselves through their use of grammar and language rules. I was also keen to hear their own story and wondered how this story might differ in alternative settings – a possible future research idea?

This then links into the “subject positions in discourse” (Burr, 2005, p.140) whereby we choose to adopt a certain position when discussing issues in particular settings with particular individuals. I shall describe this further in the interview section, however, this idea of trying to capture information from veterans in a setting where I have identified myself as counselling psychologist in training and them as a veteran, is key. I want to place my participants in this type of scenario in order to try to capture the type of subject positions they might adopt in the discourse of the interview, which may be similar to positions they would adopt in a counselling room. I recognise at this point that this has limitations in that the participants have not come to seek help from a psychologist for issues related to stress, but have been asked to discuss them as part of a research project. I shall of course discuss this issue in a later section dealing with limitations and issues with the research.

1.4 The Development of the Research Proposal

I have held a long standing interest in the provision of counselling for both current UK armed forces personnel as well as veterans from these services because of the particular nature of their occupation. We do not require any other employee to kill on our behalves, although the closest to this situation might be considered to be armed response units within the police. Because of the particular aspect of their conditions of employment, I believe this marks current armed forces and veterans out for special consideration. And so it was a natural step for me to want to research an area that might be of use when working with these client groups as a psychologist.

When considering the research question, I conducted a search for any guide which could be used by health professionals in order to understand issues facing ex-service members. I was

particularly looking for the type of published resource which highlights issues such as differences in cultures (Dwivedi, 2002) or particular stresses for occupations (Carson, Fagin and Ritter, 1995). I noted various published psychological therapy literature dealing with qualitative research of current service members and veterans but none directly relating to the language they used. There is a growing body of research using discourse analysis, some by counselling psychologists in training and I decided to employ this research method to further explore my chosen field.

1.5 Aims of Research

This research proposal aims to examine the way in which language is constructed by British ex-service personnel when discussing stress and resilience. The research question the researcher is asking is:

“What can be understood by the way stress and resilience is spoken about by ex-service personnel which may provide useful insight for the counselling psychologist?”

The researcher is interested in ways in which this understanding might be employed in general in a counselling setting with a veteran in order to break down stigma barriers to seeking help. In particular, any potential perceived lack of understanding by civilians from the point of view of the ex-service personnel of the particular demands of the occupation they were in may be ameliorated by knowledge of the language constructions others have used when discussing stress and resilience.

By examining language used by this group of people through discourse analysis, constructions of speech used for stress and resilience may be observed. In analysing these constructions, the researcher’s aim is to commence a reference resource for counselling psychologists and other health professionals working with ex-service personnel.

In terms of how this might be of use for counselling psychology going forward, by placing a veteran participant under a situation similar to a counselling session where questions are asked about stress and resilience, as may happen if a client was undergoing an assessment for a stress-related mental health issue, the researcher is seeking to see how the participant might manage their interests in the interview (Willig, 2003). That is, the researcher is interested to examine what is said; why it might be said; and how it is being said by the participant in discussing stress and resilience in an interview. It is hoped that this improved understanding

may aid a counselling psychologist in terms of styles, constructions and themes that might emerge from a potential counselling session.

1.6 Reflexivity

In qualitative psychological research, there is a requirement for the researcher to strive for reflexivity at all stages in the research process. Because it is not possible to separate the knowledge that a researcher takes into the research, they are required to consider how this prior knowledge, or social constructions, affect and are affected by the research. From the start of developing the research proposal to the current time, I have been very aware of how the social constructions I hold in various areas concerning this research area can and have affected the research process. I intend to comment on this reflexivity throughout the research to add to the richness of the data that will hopefully be produced.

2 Methodology

2.1 Research Design in Brief

I used snowballing recruitment methods to recruit participants in order to collect data which is suitable for discourse analysis and conducted ten one-to-one interviews. In the interviews, I followed a semi-structured format with guiding questions and prompts (see Appendices G, H and I) to probe veterans' construction of language when discussing stress and resilience whilst serving in the military. Once the interviews had taken place, I produced a transcription which then provided me with data upon which I employed discourse analysis methods.

When constructing the research proposal I acknowledged holding the view that, because of stigma held by the UK military personnel towards reporting stress and mental health issues (Gould et al., 2007), it might be apparent from the language constructions used when discussing these issues, that the discourse regarding stress may be negative, whereas language constructions when discussing resilience maybe conveyed in general positive terms. I was aware in expressing this view, that I was preceding the research with a point of view. I recognised that I needed to refrain from looking for these views within the discourse analysis process, instead attempting to allow myself to come to the analysis as neutrally as possible.

2.2 An examination of the epistemological position of the thesis

2.2.1 A top-down approach to epistemology

In comparison to other research papers which seem to follow a historical link to their subject in examining their epistemological basis (that is, they approach their subject from a bottom-up perspective), this research has been considered from a top-down approach. The research began with the notion of wanting to examine language and, as soon as this was decided upon, discourse analysis appeared to be the most congruent research tool to combine with the research topic. But this simplistic leap from researching language to discourse analysis left out the pathway and theoretical underpinning for this research method in the design process. Due to this leap, in trying to explain the epistemological position, the bottom-up route explanation became clumsy, and seemed to me to be incongruous and lacking in validity! In order to present a more congruent and, therefore, hopefully the most valid and valuable epistemology, I am presenting the information in a top-down style.

When considering how veterans might talk about stress and resilience, the first thing to consider is that their definitions of these words are not going to exactly match my definitions. By this, I recognise that the words do not have a permanent definition, but instead can and do change over time, within contexts and between different people. Although the experience of 'stress' may be tangibly measured physically by means of taking blood pressure readings as well as galvanic skin responses, this does not add to the lexical definition of these words. In addition, there are psychological measures which can show us if someone is experiencing anxiety which may be related to stress and resilience, but these do not consider the individual meaning of these constructs.

Rather than a physical measure or level indicator, this study is aiming to consider the language of stress and resilience. In particular, if we understand how these concepts are being constructed in the moment of an interview we might glimpse how the constructions have come about – ie what underpins them from the point of view of the veteran in this type of setting. Understanding how the concepts are developed provides us with an explanation for a few people, which might provide insight for working with others which would be considered a validation for the research.

McLeod reminds us that Freud coined the phrase 'talking cure' when explaining what psychotherapy is (McLeod, 2001, p90). Language is of key importance to our existence as humans: a communication tool, a means of expression, an instrument with which to impart information. It is as people are talking that their reality is constructed through their discourse (Wetherill, 2001). This constructive element of language was considered also by Austin in his 1962 speech act theory, who was following on from Wittgenstein's philosophy that emphasised that language was used to achieve things.

Discourse analysis is a development of Austin's speech act theory, viewing linguistic material as constructing psychological and social phenomena such as stress and resilience (Potter and Wetherill, 1987). It is concerned with how subject matter is organised and managed in speech. Along with conversation analysis and narrative analysis, discourse analysis provides the modern social scientists with a methodology to examine discourses which occur in differing ways. Conversation analysis is used where the language has occurred in a natural way – not provoked or invoked by a researcher, but a recording between more than one person about any subject which occurs naturally between them. Narrative analysis is an alternative language-

based methodology used when considering how someone constructs a story of their experience to tell the listener about a subject.

Discourse analysis, by comparison, is often employed when a conversation does not occur naturally between people, such as a recorded interview. The analysis is not concerned with the person's story per se, but instead in the construction of the language, the role the language performs and the person's positioning of themselves within the discourse. This type of speech production is reminiscent of the type of exchange that occurs in a counselling room, where the conversation is not one which would naturally occur, but is produced in response to the setting. Due to this variability in constructing speech in different settings, this is not considered a methodological issue with discourse analysis but instead is viewed as an interesting feature (Marshall, 1994).

Discourse analysis can be subdivided into two approaches: critical discursive analysis and Foucauldian discourse analysis. Whilst some have highlighted the two approaches as distinct from one another (eg Antaki et al., 2003), others consider the two to be blended (eg Edley and Wetherell, 1999), all see this type of methodology as a new way of conceptualising research questions and understanding areas of psychological research. The hope is that analysis will produce an intricate explanation, based on the action-orientation of the discourse. Whilst the work is emic – garnering meaning only from the participants involved, due to the nature of the work they did and the organisation they belonged to, the analysis strays in Foucauldian analysis by looking at the wider socio-political processes which might be underpinning the language production.

In carrying out discourse analysis, Willig (2003) points out that, as opposed to talk being “a route to cognition” (Willig, 2003, p160) the responses received from the participants will be dependent upon the context in which the interview takes place. Because of this, no assumptions will be made about the wider population of ex-service personnel with regards to attitudes and beliefs. In addition, general rules about cognitions will not be possible to be drawn from the data as each participant will hold a different perspective with regards to stress and resilience from their career in the forces.

Discourse analysis allows for the recognition that the construction of language of stress and resilience by participants may have been built within the institution that these participants have worked ie the forces as well as in sub-groups such as regiment, company, battalion, and unit and that rather than stress and resilience being “consensual objects of thought” (Willig, 2003,

p162), these constructs are built up socially through language and therefore participant's expressions are expected to differ due to their personal experience of these constructs. Finally, in considering discourse analysis, instead of being "relatively enduring cognitive structures" (Willig, 2003, p162), it is expected that the participants discourse around the subjects of stress and resilience will differ and it is hoped that the analysis will draw out something about the participant's interaction with the constructs ie some type of language performance.

Discourse analysis in its wider form is clearly rooted in social constructionism (Burr, 2003). This approach views the words/phenomena of stress and resilience, as mentioned before, not as concrete constructs which each person would acquire set knowledge about, but rather as social constructions which alter with variables such as time, experience and perception (Burr, 2003). Within the social constructionism remit, language is considered essential as a form of interaction and also as a mechanism for acquiring knowledge of constructs such as stress and resilience.

The work of Gergen (1985) is key in the development of social constructionism as an epistemology. According to Burr (2003) it relies upon three assumptions: that instead of adopting a 'taken-for-granted' (p.3) attitude to phenomena, instead, the researcher must try to shed their pre-suppositions and develop an explanation from the material that they are studying. Secondly, phenomena are not static throughout history and across different cultures. Instead, as each learns about the phenomena, the language that surrounds the phenomena is constructed socially and therefore, the research will be bound to the time and place it was carried out. The final assumption is that phenomena are learnt about by being in community with others and that knowledge is developed, understood and passed between people. There is literally a social construction of all phenomena.

In terms of this research, applying these three assumptions has led the researcher to consider that I must not take for granted any joint understanding of the concepts of stress and resilience. Instead my role is to uncover the meanings of the participants. Secondly, these phenomena are not static but will change according to the person I am speaking with and also, will change according to the person's experience of them. And finally, the participants will have learnt and passed on constructions of stress and resilience, which may or may not be similar as they have all served in the armed forces.

2.2.2 Validity of Qualitative Research

Morrow (2005) highlighted the need for qualitative research to consider issues such as credibility, transferability, dependability (or trustworthiness) and confirmability of the data sources used and outcomes (Morrow, 2005, pp251-2). Whereas quantitative research can be readily tested statistically for both internal and external validity, there is no such universal “measure” for qualitative work. Without such statistical testing, the qualitative researcher is required to convince their readers of the validity of their work through other means. In addition, Morrow continues that using a constructivist paradigm leads to the knowledge, which is being drawn from the data, leads to it being both idiographic – gleaned from a few participants rather than a large scale survey – and also emic – teasing out the meanings provided by the individual (Morrow, 2005).

In order to produce a thesis which can be seen to show validity, have meaningfulness and contain useful insights, I have relied heavily on researcher reflexivity to explore and tease out the thought processes which occurred during the production of the research. This exploration has been as honest as possible in order for the reader to capture the sense I made of the interviews and the emerging repertoires. Through these reflections, it is hoped the reader will be convinced of the authenticity of the analysis, which is seen as a qualitative measure of credibility.

Another means of ‘proving’ validity can be the use of triangulation after analysis. At the time of developing the thesis proposal, I approached a psychologist who was willing to assist in this. In addition, some researchers use their participants to act as ‘triangulators’, by seeing to what extent they agree or disagree with the findings in the analysis. I did not pursue either form of triangulation, instead preferring to use researcher reflexivity to provide a triangulation for the work. This is because I realised that in analysing the work, it is impossible to sever my personal input from the analysis. By attempting to be as authentic as possible, it is considered that this is grounds for acceptable qualitative work (Miles and Huberman, 1994).

One criticism levelled at qualitative work is that due to the small number of people being interviewed, the information cannot be readily applied to a wide-cross section of the relevant population. However, Elliott, Fischer and Rennie (1999) suggest that to overcome this, the researcher interviews and analyses data from as many people until no further new information is gleaned. In this research, I did not aim to reach saturation point by carrying out multiple

interviews until no further repertoires could be distinguished. Instead, I used interviews to draw out the main repertoires which usually appeared in at least one, but more often, more than one participant. Instead of using saturation as a measure of the research, the aim was to draw out meaningfulness and insights. Potter and Wetherell (1987) describe this qualitative measure as 'fruitfulness'- where the reader can gain insights from the analysis work of the researcher.

Furthermore, in examining the notion of trustworthiness of qualitative research, Yardley (2008) considers four key areas which should be the aim of the qualitative researcher, although she concedes that some points may be more achievable for some research areas. These key points are: sensitivity to subject; commitment and rigour; coherence and transparency; and impact and importance. These areas are in addition to processes such as consulting the participants to discuss the results for feedback and using other psychologists to confirm the repertoires being drawn out of analysis. In order to maximise the trustworthiness of this research, the key points which have been particularly concentrated upon are sensitivity to context and impact and importance. This is particularly the case in looking at the speech of veterans which does not appear to have been researched before and trying to find new ways of understanding this client group. It is hoped that the participants and other veterans might see this research as being culturally sensitive to the military and that the analysis has been carried out with this group particularly in mind. The researcher has also considered how this research might impact on the practice of psychologists and others working with veterans.

The other pointers which Yardley indicates are key for trustworthiness are not themselves bypassed in this research. Indeed, the use of reflection, as described above, aims to improve the coherence and transparency of the research. By providing the reader with the reader with working notes, I have attempted to provide evidence of a 'paper trail' for readers and demonstrate the insights I had in analysing the veteran's transcripts.

As the work is personal and subjective, the realisation from myself is that my constructions regarding stress and resilience will affect the analysis I do of the participants constructions of stress and resilience. Following in the tradition of Gergen (1985), the qualitative nature of this work relies on producing an understanding of the subject matter, rather an explanation for it. In this sense, there is nothing concrete about the social constructions of the research area, but instead, repertoires that are changeable.

2.3 Research Design in Detail

2.3.1 Recruitment

In order to recruit participants to this study, I decided to use the snowballing technique of emailing or phoning contacts already known to me who have served in the forces, asking if they or any of their colleagues might be interested in participating. In addition, I emailed a network of friends, colleagues and contacts currently in the forces who may themselves know potential participants. I used the introductory information in Appendix C to explain the nature of the research and what I was expecting from participants.

A snowballing method for the recruitment of participants was used as it was easy to email all my personal and professional contacts in the first instance with the recruitment literature. The method has the advantage of being free with the possibility of quick responses, compared to other methods such as posting recruitment leaflets by land mail, or putting up poster in possible locations in the hope of attracting participants. In addition, as it was envisaged that only a relatively small number of participants would be needed to be interviewed (up to ten), the potential recruitment pool did not need to target hundreds of people in the first instance.

A key reason for using a snowballing method for recruitment of veterans is because the method targets potential participants who might otherwise be hard to reach. The use of the snowballing technique was based on pragmatic reasoning; since I was looking for a relatively small number of participants, I believed this would help overcome some barriers to possible participation if the invitation came through a known source. In meeting with contacts at the Royal Air Force to discuss the nature of my research, I was reminded that, without the personal contact, people might be unsure about speaking to me. This could be due because potential participants would not know whether I was a “friend or foe” who could use the information I gave them to be negative about the UK Armed Forces. As this was not an aim of the research, I felt the best first stage was to ask those known to me for assistance in recruitment. In this way, the potential participant had a means of finding out about me through their contact. In addition, due to the personal nature of the initial contact, I was afforded the opportunity to reassure any potential participant that I was a “friend” and did not have a negative agenda towards the institution of the Armed Forces. Other sources would have been approached if the snowball method had not raised enough participants, eg placing posters in Royal British Legion Clubs and charities working with veterans.

The disadvantages of the snowballing recruitment method were also considered. One issue was that the email did not reach a diverse selection of the potential target group of participants. Many of the contacts I was in contact with were commissioned officers and this issue is considered in Section 4: Synthesis as to how this selection method might influence the results of the discourse analysis.

An initial 96 emails were sent out and ten responses were received. Of these, one was a direct response to the email and the other nine were from the email being passed onto them by the initial contact. All ten emails were replied to and from these, four interviews were subsequently arranged and were carried out. The other six of the initial responders were sent an additional two emails by me, the first containing further information about the study with a request for participation and confirmation by email. When this was not responded to, the second email was sent to see if the person still wanted to participate. A non-response to this last request was taken to mean the person did not want to participate. No person who responded was rejected by the researcher; instead, each person was asked to self-check that they believed they were suitable for the research.

In addition to the snow-balling method using emails, two interviews were conducted after a personal introduction to potential participants at a Royal British Legion event in London. Details of the study were sent to the individuals and, having allowed them time to read the information, interviews were arranged and conducted.

I was aware that some respondents might have felt pressure from friends or ex-colleagues, and I wanted all potential participants to have a cooling off period where they could decline their participation. I was also keen to emphasise that I would be asking them to talk about personal experiences of stress during the interview and allow enough time for them to consider if they were prepared to do this.

The final participants were recruited through a second round of emailing the recruitment letter to a limited group of six contacts. Each participant was indirectly recruited via one contact from this list of six. Details were sent to each of the three, who all agreed to participate and the interviews were conducted.

In total, nine people were interviewed. A tenth interview was recorded when the first participant (who had already been interviewed) expressed a wish to speak again, and this

recording makes up the tenth interview. A gamut of issues regarding re-interviewing a participant will be considered in Section 4: Synthesis.

When initially proposing this research I was aware that men make up around 90% of total military personnel, so in order to reflect this, I had been expecting that at least 90% of the participants would be male. In the end, all the participants were male. At the time of the proposal I had noted that it was apparent from figures from the MOD (Gould, Sharpley, and Greenberg, 2008) that whilst women are reporting mental health issues, men are under-represented in figures seeking help. At the point of proposing the research, I reflected on this issue and although I had initially aimed to recruit participants in order to reflect this male-female divide, I found myself becoming particularly interested in the male style of discourse concerning stress. I made the decision that I would not actively try to recruit any female participants but would have welcomed any if they had become available.

At the proposal stage of the research, I was also aware that the numbers of personnel in each type of service is currently split between the services as approximately 25% Royal Navy, 50% Army, 25% Royal Air Force and considered how a similar percentage split of respondents might be achieved this in terms of recruitment. In addition, I was interested in both commissioned and non-commissioned personnel and initially sought to have an even number of participants from these groups, ie five commissioned participants and five non-commissioned participants. In reality, I did not exclude any participant who was willing to be interviewed based on any prior knowledge I had concerning which service they were in or whether they were commissioned or not. I will explore these issues further in the Biographical Questions section below, as I reflected on them during the recruitment period.

2.3.2 Biographical Questions

In the initial proposal, in addition to a semi-structured interview, I decided to ask participants various biographical details (see Appendix J). The reason for including these biographical details was to introduce an element of comparability with other military health research which includes this type of detail in discussing the participants who have been involved in the research. Various studies, such as Hoge et al. (2004), show that biographical factors can affect susceptibility to mental health issues following service.

In developing the research proposal, I knew that I had not fully subscribed to the social constructionist epistemological basis of the research, as described in the introduction section,

and initially included the biographical questions so that the research would have, as mentioned above, an element of comparability with the myriad of quantitative research that is conducted concerning veterans both here in the UK, in the USA and throughout the world. There was a sense of being practical, or perhaps, commercial in positioning my research alongside the quantitative work – giving the quantitative researchers something to “hang onto” when considering my work. Ponterotto (2005) would argue however, that the inclusion of such quantitative information in a qualitative piece would be an example of “postpositivising”. As he describes, this involves the researcher trying to force “a round peg into a square hole” (Ponterotto, 2005, p.127). This is where the researcher aims to conduct qualitative research but is affected by a backward glance at the earlier traditions associated with quantitative work.

I recognise that, although I wanted to embrace the social constructivist position of considering how the participants constructed their understanding and experience of stress and resilience through language, I had not fully engaged with the approach at the proposal stage. This meant that I was trying to tie the participants to some reality that could be generalised to other studies, but would be contradictory to the epistemological position of the research.

In light of the above postpositivising issue, I was reluctant, initially, to address some of the issues I considered with regards to recruitment but I felt that an awareness of these issues was important. Only one out of the nine interviewees was a non-commissioned officer. The expressions by these two groups may be very different based on the contexts within which they served, and as the services are known to be culturally hierarchical (Langston, Gould and Greenberg, 2007), I have considered that their discourse could reflect these differences.

In terms of trying to recruit similar percentages of interviewees according to the service they had belonged to, I made the decision that I would not turn anyone away who offered to participate. However, I was aware at one stage I had had no respondents or suggestions for contacts for veterans from the Royal Air Force and approached two personal contacts to ask if they could suggest any ex RAF personnel. The reason I did this was because I felt the inclusion of someone from a different service could enrich the analysis and might have provided further information.

On a minor note, the order of the services on the biographical information handout was altered following the first interview as it was pointed out to me that the services (Royal Navy, Army and Royal Air Force), being hierarchical in nature (Langston, Gould and Greenberg, 2007), were in the ‘wrong’ order, according to the historic establishment of each service. The

format now reads: Royal Navy, Army, Royal Air Force rather than Army, Royal Navy, Royal Air Force. I was aware that correct usage of terminology could be very important to potential participants and so amended this format in the interests of standardisation.

2.3.3 The Interviews

In an ideal scenario, data used for discourse analysis would be naturally occurring dialogue between at least two people. This is because some have reservations as to the legitimacy of interviews in qualitative research (eg Potter and Hepburn, 2005). This is because there is the danger of considering the information provided in interviews as concrete and applicable to a wider population, ie a positivist stance. Indeed, those from the ethnographic and conversational analysis disciplines might dismiss any type of interview from their research.

In the early stages of the research proposal, I considered a variety of ways in which a legitimate dialogue might be achievable, with varying degrees of naturalism. One idea was to ask a group of participants to watch a video of Canadian veterans talking about their experiences and then ask the UK veterans to discuss the video in relation to their own experiences. I rejected this idea as being too restrictive in potential scope - it seemed unlikely that a group of friends or strangers would be willing to talk openly about their own experiences, especially when I considered the low rate of reporting mental health issues due to perceived stigma (for example, Hoge et al., 2004).

The next scenario I considered was to ask a group of veterans who knew each other to take part in a group interview, possibly holding the interview in a pub or Royal British Legion room, where alcohol would be served. I considered this, as I was trying to decide what would constitute as natural a setting as possible. I have been witness to friends sitting around, drinking and discussing their previous service life. I wondered whether, as there would be minimal interaction between me and the participants, what kind of data might be achieved through this method. In particular, where I might want the veterans to talk about stressful periods of their service, they might veer off topic. Having a moderator who 'guided' the conversation might have overcome this, but would have been departing from the idea of attempting to record 'natural' conversations.

Tying in the prior consideration about stigmatisation of disclosing stressful incidents, I was also mindful of the potential problematic relationship that some participants might have with alcohol. Research shows that incidences where alcohol use has played a negative part have

increased in an occupation which already has a high alcohol intake culture (Fear et al., 2007; Langston, Gould and Greenberg, 2007) . In terms, of ethical issues, it was foreseen that there could be a variety of objections to the use of alcohol within this type of set up. The same set up was considered without the alcohol, however, this was dismissed as not being naturalistic – defeating the objective of seeing if this scenario would be achievable.

Eventually, I decided that I wanted to position myself in the room with the participants in one-to-one interviews, as a counselling psychologist would sit with a new client who was a veteran, in an assessment session. As most sessions run by counselling psychologists are run as the therapist sitting with a client, I felt that this set up would, in a limited way, replicate a typical assessment session where the counselling psychologist both listens to what the client says, but also has a series of questions that can be covered if the subjects do not come out in the assessment. Where it diverges from a counselling session is the purpose of the two people meeting – for an interview rather than for therapy.

I did consider how it would be for the interviews to be conducted, say by a male interviewer. As a large number of counselling psychologists are female, and therefore, clients accessing a counselling psychologist would probably be assessed and treated by a female, I felt it was important to hear the discourse that was produced to a female. In deciding to conduct the interviews personally, rather than a female colleague, I was aware that part of the discourse analysis procedure allows for change in questions being asked (Potter and Wetherell, 1987). I also wanted to be able to draw participants out if the needed extra prompting in order for the data to be meaningful (Conrad, Blair and Tracy, 2000).

Having had to re-examine the questions I had proposed initially in resubmitting my proposal my initial set of questions (see Appendix G) were used to form the basis of the first interview. In addition, I had a series of probing questions I kept alongside the main questions, which I could employ to ensure full and explicit answers (Appendix I). However, during the first interview, I realised that some questions were not fit for purpose, such as asking them to characterise times of stress and resilience. The question was clumsy to ask, hard to understand and did not produce personalised accounts. Instead, this question was re-worded to “Please will you give me examples of times of stress and resilience from when you were serving? How did you deal with them?”. In similar ways, other questions were developed so that they became more relevant including the prompt questions. The prompt questions were particularly important in drawing out further information, especially as research by Wilson,

Jones, Hull, Hotopf, Wessely et al., (2008) show a small effect of recall bias as a potential protective factor against PTSD.

As the interviews progressed, the questions used were further added to and the final list of questions can be found in Appendix H. The advantage of being the designer of the questions, the researcher and the interviewer meant that during the interviews, I adapted questions to fit what had already been spoken about by the participant. I was also able to use information relating to the biographical details to encourage a more conversational style of discourse within the interview, and also had the chance to use hypotheses with participants based around their responses in order to draw the participants more fully in expressing issues connected with stress and resilience.

In all instances, when considering the questions, I reminded myself of my research question first and foremost. I tried to avoid technical psychological language, as suggested by Potter and Hepburn (2005) although they recognise that this is not always possible. In phrasing the questions, I considered research as recommended by Iversen, Fear, Ehlers, Hacker-Hughes, Hull, et al. (2008) where predisposing factors may contribute to the development of PTSD. Also, in another study, Greenberg, Thomas, Iversen, Unwin, Hull and Wessely (2003) found that service personnel were more likely to find an informal outlet for discussing distressing events rather than using formal psychological therapy and this led me to ask what a participant would do if he saw a colleague struggling to deal with stress.

In practical terms I recorded the interviews using an Olympus Digital Voice Recorder WS-100 placed usually on a desk between myself and the participant or beside us. The recorded interviews were then transferred into password protected files on my computer and then transcribed by myself.

The interviews were conducted in a variety of settings ranging from participants' offices or meeting rooms at the participant's place of work; participants' homes; and rooms at City University. In all cases, the interviews were conducted in a private room to protect the participant's identity. Whilst interviewing the participant, I attempted to avoid using the participant's name and when transcribing the interviews, any identifying information pertaining to the participant was omitted or changed. This included colleagues names, some locations and references to their regiments, bases, ships and so forth. For security reasons, details of interview locations were provided to my Research Supervisor and calls were made to her before and after the interviews.

2.3.4 Consent, Ethics and Confidentiality

Consideration has been given to the mental welfare of the veterans who participated in this research, especially in light of literature which reports that veterans, on average experience a breakdown in mental wellbeing 13 years after leaving service (Southwick, 2008). In addition, incidences such as the anniversaries of various campaigns and media broadcasts can precipitate a worsening of mental well-being. In order to prevent mental stress, all potential participants were fully briefed on the extent of their participation and the topics that were to be covered ie stress and resilience. The briefing document (Appendix D) was sent to all participants and was further discussed between the participant and myself before any taping commenced. Once the briefing was fully understood, each participant was asked:

“Is there any reason, after reading the briefing document, why you do not believe it is appropriate for you to take part in this research?”

If any potential participant had answered “yes” or had any doubts, they would have been discouraged from participation. They would also have been offered the opportunity to discuss any issues with myself and would have been directed to other sources of help and information (Appendix K).

All participants answered “no” to the above question, so they were asked to sign a consent form, (Appendix F) which confirmed that they were entitled to withdraw at any point during the interview or afterwards, without recourse.

Following participation, all participants received a debriefing info sheet (Appendix E) which I also explained verbally. I then provided the participants with information on useful sources of information (Appendix K). This included both mine and my supervisor’s contact details. Finally, the right to withdraw was made clear at this point, if they decided that they did not want their interview to be included in the research.

The researcher has considered that there could be a possible conflict of interest in recruiting some participants who were personally known to the researcher. A full briefing, in line with directions above, was given in these circumstances and a cooling off period was applied after they agreed to take part in the research. Issues regarding potential conflicts with confidentiality and sensitive information were made explicit to personally-known participants in order that they could make a fully informed decision on whether to participate or not.

Where participants potentially knew one another, I made it clear that participation in the research would neither be confirmed nor denied by myself to safeguard their anonymity. However, I informed all participants that no restriction was placed on them and, if they wished, they could discuss their participation with anybody.

To confirm, I only commenced the recruitment and interviews once the City University Ethics Committee approval was given. In addition, I am bound by the professional code of conduct and ethics of the British Psychological Society, of which I am a member.

2.3.4.1 Consent, Anonymity and Publication

All participants were asked to sign a consent form (Appendix F) before participating in this research. This included elements such as 'I have been given an opportunity to ask any questions regarding this information' and 'I have been made aware of what my participation involves'. The form did not specifically inform them the thesis would be held publicly. At the time of the design of the research, the BPS did not require this and, perhaps in an oversight at the time, I did not include this. The issue of publication without specific consent has subsequently had to be considered particularly with regards to participant's quotes being available in the public sphere. Should all the participants be traced and contacted for post-write up consent? What would the implications of this be? How would non-consent or non-traceability issues affect the work produced?

Although psychologists are not required by governing bodies, such as BPS, to specify about publication when asking for consent from participants taking part in academic research work, it is expected that all material would be anonymised in all work. By anonymising any personal details, such as names and locations, participants should not be identifiable in any way, which might be included in the published work. We ask a person to reveal something about themselves for the purpose of our research. Subsequently, we have a duty of care to look after the person and the information they provide to us. As a researcher and a clinician, we are entrusted with personal information which must be dealt with in a confidential matter.

In weighing up the requirements and ethical issue regarding consent to publish, I decided that to try to trace all the participants, some four years after interviews took place, would be

subject to practical obstacles. These include out of date contact information; sensitivity in what was spoken about during the interviews; concerns about the possibility of consent being withheld and subsequent re-workings of the research that that might entail. It was also considered that some of the participants would be traced, but possibly not all – would information by the non-traceable also have to be removed?

This difficult issue was considered in great depth and it was decided that further consent would not be sought. In order to ensure anonymity of the participants, a review of all information in the thesis relating directly to the participants was carried out, with some further anonymising of potentially identifiable information being carried out, so no participant could be recognised.

With regards to the on-going security of data, only I have access to the recorded interviews, via password protected files on my computer, although a paper copy of the transcripts was made available to my supervisor for the purpose of the research. In addition, I made a hard copy of the transcriptions in order to facilitate the analysis stage of the research. These hard copies are held in a locked, fireproof cabinet when not in use which only I have access to. Once the analysis stage was completed the hard copies will be kept for a period of one year and then will be securely destroyed by shredding and burning.

2.3.5 Data Analysis

Before any of the transcriptions were completed, I took the opportunity to listen back to the interviews, firstly in order to get a sense of the discourse styles being used by the participants and to “hear” what was being said. I also used this opportunity to note down where the semi-structured questions I had asked did not seem clear or seemed incongruous to the research question. Once this was completed, I then started the process of transcribing the one-to-one interviews.

Potter and Wetherell (1987) have a short form guide to how transcripts can be notated. This is expanded upon by Potter and Hepburn (2005) who list “conversational features” (p.8) including various elements such as volume indicators, where a speaker’s volume is raised or lowered, speed where a speaker might speed up. As I am not a linguist by trade, and having found the notation of some linguist’s transcripts confusing (eg Kitzinger and Frith, 1998), leaving me with little idea of how an interview or conversation flows, I have not stuck rigidly to the suggested transcription notation mentioned above. Instead, I have used grammatical

notation such as commas and full stops to indicate pauses or downward inflections which suggest the end of sentences, whilst including elements such as bold text to indicate emphasised words.

In addition, I had not attempted discourse analysis before so I felt like a beginner and when I looked at texts where a fuller notation was used, as described above, I was often left with a feeling of confusion by the meanings of the notations. In shying away from using suggested notation and preferring to “make up” my own, I saw the production of the transcripts rather like stage scripts with notes to the actors held within the lines. I had developed this notation based on transcribing client sessions for coursework requirements, and has become used to (at least to my mind) a simple type of notation in my transcripts. I am aware that this might not reach the criteria set by more experienced discourse analysts; however, I am prepared to keep to my own system. I am heartened by research from Harper, O’Connor, Self and Stevens (2008) who examined issues such as this and found that other doctoral students found themselves in similar positions. Although they noted that the lack of information on the actual process of discourse analysis allowed the researcher greater freedoms in exploring the texts, this did not necessarily reduce my anxiety about getting the analysis “right”.

Throughout this stage of discourse analysis, due to the qualitative nature of the work, I have attempted to remain as neutral as possible in terms of predicting potential findings from the interviews. To this end, no coding or categorisation was initially provided at the point of proposal. During the analysis stage, I was looking for systematic patterns and checking what these patterns might account for as well as what they do not account for. Using the guidelines of Willig (2003), analysis was concerned with elements such as both linguistic and non-linguistic aspects of the discourse as well as considering what the discourse was achieving from my point of view and the action orientation of both the participant and me. Other important issues that I considered included the context of the text, its variability and its construction (Willig, 2003). I also checked both for similarities in language used as well as variations.

An extra step I included was to keep a reflections document open at the time of transcribing so that any thoughts or notions which became apparent in the present moment were recorded and were made available for inclusion at the “Analysis and Implication” section (see example in Appendix L).

In addition to the reflections document being readily available at this stage, I also developed a list of analysis cues (see Appendix M), these have been drawn from the various writings about

doing discourse analysis (such as Willig, 2003). By having the list of cues at hand, I sought to reduce any anxiety I might have felt from potentially missing structures from the repertoires. I also found it useful to keep my focus on the discourse structures rather than on themes.

The reader of this thesis will note in the “Discourse Analysis” section that many of the descriptors of the repertoires begin with the letter “d”. I was challenged about this by a fellow student early on in the analysis stage, but I realised how, when both conducting the interviews and listening back to them, I was struck by how many words I was using to describe the discourse began with the letter “d”. I was concerned that the use of these “d” word descriptors might be viewed as a bias and I spent considerable time taking into account other ways I might report on the repertoires of the interviews. However, despite trying to ‘allow’ myself to develop alternative descriptors, and reduce potential bias, I was drawn back to the original list of descriptors, which seemed to be an organic thought process from the start, although reflective of my interpretations.

With regards to the definitions of these repertoires, some of them are used with different meanings by various psychological approaches, especially in the psychodynamic tradition. For the purpose of this research I have tried to use constructions based on the ways the interviewees have discussed stress and resilience with me. In using these “d” words, I have drawn examples out from the interviews to give a fuller meaning of how I have used them. I would ask those reading this work, who are familiar with the meanings attached to some of these words particularly from psychodynamic traditions, to suspend these definitions, in order to listen to the new meanings “socially constructed” here.

Following the completion of the analyses of the repertoires, the next stage was to consider the validation of the analyses. For this next stage, suggested by Potter and Wetherell (1987) I had envisaged enlisting the services of an independent person to check the coding and analyses made by me. This stage was considered for inclusion in order to strengthen – validate – the examination and assertions I had made. Some question whether this stage needs to be done, in the epistemological spirit of qualitative research (Ponterotto, 2005). Upon further exploration of other’s experiences of carrying out discourse analysis (eg Harper, in preparation), it seemed to be more appropriate if I was to approach some of the veterans I had interviewed to discuss the repertoires I had noted and to ask them for comment. This has been possible in one case and I have included the outcome of this discussion in the “Synthesis” section.

I have also broken with the tradition of including a discussion section. Instead, by applying the results of the analysis to the practical issue of commencing a resource which might be of use to other health professionals in counselling veterans.

In place of a discussion section, lies “Synthesis” which expands on the emergence of a discourse superstructure, as well as other emerging themes from the discourse analysis. The final stage of the research was to offer my reflections on the research process. Following the transcription of the interviews, according to the stages of discourse analysis as described by Potter and Wetherell (1987) I reflected on the discourse used by myself and this is also to be found in the “Synthesis” section. In order to do this, I used reflexivity in considering my role in the discourse, and consideration was given to the potential view of me in the role of civilian counsellor in a potential therapy session, and the effect this has on my language construction as well as the potential effect on the participant.

3 Analysis

3.1 Analysis of Interviewees Biographical Details

Nine veterans were interviewed; one of them was interviewed twice to total ten transcripts. All of the interviewees were male. Two-thirds had served in the Army, whilst 22% (2 interviewees) had been in the Royal Navy and one interviewee (11%) had served in the Royal Air Force.

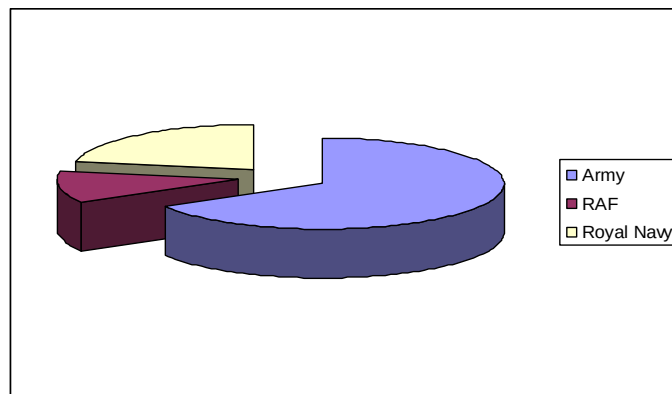


Figure 3 Interviewees – Service Analysis

In light of the mix of employees within each service in April 2010 (Royal Navy – 20.2%; Army – 56.8%; RAF – 23%)², described previously in the methodology section, these broadly reflect the numbers in the Royal Navy, although the percentages for the Army and Royal Air Force are slightly more divergent.

Combat Stress, the UK's leading veteran's charity, starts to see veterans, on average, thirteen years after they left service. The interviewees' average number of years since leaving service is also thirteen, so this group of men reflect the type of veteran who seeks specialist mental health services. In addition, the average number of years the participants served was nineteen – those seeking specialist help is so comparable.

² Figures derived from the Defence Analytical Services and Website latest available figures for numbers of service people per service. <http://www.dasa.mod.uk/modintranet/UKDS/UKDS2010/c2/table210.php>

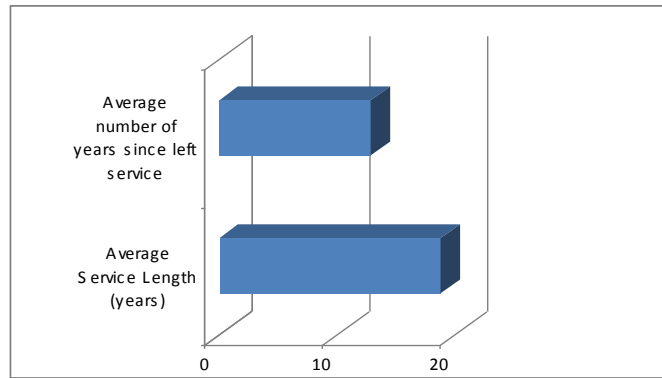


Figure 4 Interviewees – Length of Service

A major difference between the veterans approaching Combat Stress is that over 90% are non-commissioned officers (NCOs) whilst in this study, 89% of the interviewees were commissioned officers (COs) whilst just one interviewee (11%) was an NCO.

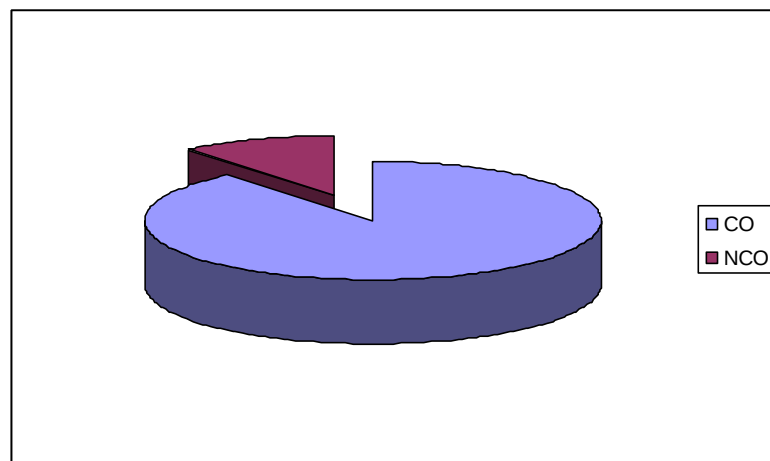


Figure 5 Interviewees - Rank

Reflecting this mix of COs versus NCOs, 78% of interviewees had achieved A' Levels before joining up, with 11% either having O' Levels or a degree. Studies looking at protective factors against PTSD developing are rank and educational attainment (Hoge et al., (2004); Ikin et al., (2004); Fiedler et al., 2006); Ursano, Benedek and Engel, 2007).

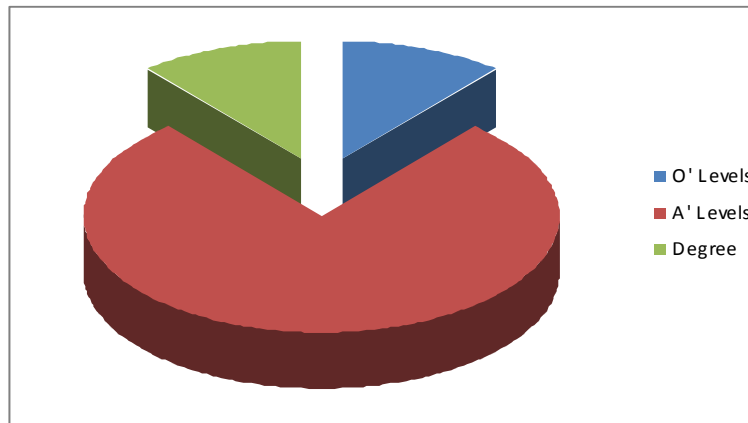


Figure 6 Interviewees - Education

Having made this point, it is pertinent to consider that this group is not immune to the effects of stress and some consider that there are many COs who are indeed suffering from the symptoms of PTSD but who do not make themselves known to Combat Stress (Busuttil, 2009). Indeed, the organisation does take calls from these people but they decide not to come in as most of those attending at NCOs and it is thought there is little understanding between the ranks of the other's issues. Anecdotally, many of the NCOs attending will hold their COs to blame for the situations that they ended being up in.

3.2 Discourse Analysis of the Interviews

Through discourse analysis of the transcripts of the interviews, twenty one repertoires have been noted and these have been separated into five groups:

Professional/Objective	Direct Details
Personal/Subjective	Duplication Descriptive Figures of Speech
Exclusive	Derogatory Difference Distrust

	Directive
Mind-Body Connection	3D Physicality Defence Mechanisms Disturbed By Design Dependability
Refutation	Denial Defensive Downgrading Personal Pronoun Defective

3.2.1 Professional/objective

Two repertoires have been assigned to the professional, objective group:

- Direct and
- Details (Debrief).

The function of these two repertoires is to provide the listener with professional and objective information. The professional discourse contains military terminology and figures of speech, presented in a business-like manner with little or no personal information. The discourse often contains no personal pronouns and there is a lack of non-verbal discourse which might be suggesting the speaker is comfortable and used to delivering objective information in a professional way. The effect of the discourse on me, as the listener, was to imagine being in a military debriefing session, hence the addition of this title to the Details repertoire.

3.2.1.1 Direct

The direct repertoire is recognised by language style – the style of speech contained few adjectives and adverbs, as well as by the oral delivery which was straight to the point with no preamble to the content. In addition, the responses came quickly and without embellishment.

This suggests that the function of the speaker is to deliver information in a succinct and clear fashion. An example of this type of repertoire can be heard from William:

“his brains were all over the pavement” – William, 2:17³

This phrase comes early into the interview with William, so one could say he was addressing someone who was far from known to him. Whereas someone else might have used less dramatic language, William is very direct in his language, pulling no punches in his choice of words or delivery style. The function of the repertoire delivers the information in a direct fashion.

3.2.1.2 Details (Debrief)

The function of the details (debrief) repertoire seemed, to me, to be similar to an account a military person would provide at work – ie details which would be provided in a professional debrief. The role the veteran was taking was to provide a factual account of events without personal embellishment. As well as the functional analysis cues, the details repertoire includes military operations terminology; a fast delivery pace of speech; few pauses, repeats or repairs in oral delivery. There are very few non-verbal interruptions in the communication. Alfie describes a sortie that took place in a recent conflict zone, as an example of the details/debrief repertoire:

“everyone knew they were going out of the gates and everyone knew there were IED’s all over the place and anyway it wasn’t specific and they weren’t going until morning well, it was after midnight so we did all the briefings and we went to get some sleep for about three hours before we all got up to start the operation and it must, in that time, just before we going to go to bed, a message came in saying there was an IED on the road which was the route they were going” – Alfie 3:1-5

On ‘hearing’ this passage, I imagine that Alfie might say this kind of thing in a debriefing situation. In considering language as performative, I envisage Alfie as the service personnel recounting details of an operation to those who need to know in the guise of someone who is providing information. In his choice of language, there is very little

³ References for quotes indicate page and line numbers from the relevant transcript

personal detail – it remains professional and objective, hence being assigned to this group.

3.2.2 Personal/subjective

The following repertoires are described under the titles of personal/subjective:

- Duplication,
- Descriptive and
- Figures of Speech

In contrast to the previous group of repertoires, these three seem to indicate a more personal language style. There is a difference in the type of words used which reflect the person speaking them, including figures of speech, which would not be appropriate in a professional or objective discussion. The delivery of the words includes repeats and the construction of the discourse suggests a more narrative type of discourse. This narrative style performs the function of providing the listener with a richer, more personal, and more subjective account of what is being said.

3.2.2.1 Duplication

The first repertoire in this group is the duplication of words or phrases which appear to emphasise points that the interviewees wish to stress to their listener – a function of the discourse. The choice of words also provides the listener with a picture of what is being described as well as clues to the meanings and values that the speaker wishes to convey. The use of duplication in the conversation also demonstrates the individual's semantic styles. There are many examples of these in the interviews and the following give a flavour of this repertoire:

“and that is one of the great strengths, great strengths of the services” – William 5:6

“they get you used to dealing with confusion and dealing with uncertainty and dealing with responsibility and dealing with all that” – Alfie 5:22-23

“I’ve known very, very, very unpopular people in the army” – Joshua 6:17

“I can remember the quartermaster at one stage who was a wonderful, wonderful leader” – Joshua 17:5

“he would know innately if someone was inadequate and he would help them, help them, help them to be better than adequate” – Joshua 21:4-6

“but it was fine, funny, funny, funny, funny” – Joshua 26:18

“within minutes there were three hundred very drunk, very violent, very angry Irish people” – George 2:23-3:1

“if you do it day in, day out, day in, day out” – George 14:1

“the other thing, you know, is practice, practice, practice” – Oliver 8:3-4

In considering language as performative, again, one could argue that duplication of words not only represents something of the character of the person saying the words, through the choice of words spoken, but also for their style of speech. Joshua 26:18 seems to reflect a moment of remembering a comedic incidence, whilst George 14:1 reflects, possibly, a personal tiredness in repeating an action over and over again and possible boredom.

3.2.2.2 Descriptive

I have used the word descriptive to describe the next repertoire where a more narrative function within the interviews appears to be provided by the veterans. The language seems to be more expansive with rich description of situations being faced including the personal experience of the situation which would not be included in a debriefing situation. The semantic styles of the individuals varies, as would be expected from narratives, some producing a comedic style of talking, some using more emotive language, whilst others produced what seemed to be a historical record of some of their service life. Whereas the professional and objective repertoires are delivered in concise ways, with little repetition, pauses, repeats and little non-verbal interruptions, by contrast, this descriptive style includes all these mentioned as well as divergences to explain to the listener issues outside of the situation. There is also the inclusion of personal reflections concerning the situation, either remembered information prior to the event, from the time of the incident or concerned with processing of information from the event subsequently. One particular example stands out:

“Er, I don’t, I think it’s more the not knowing than the knowing (mm) erm to sort of put that into perspective. On one occasion we had a one of my soldiers in my company was shot dead outside our barracks and I went out to see him and you know his brains were all over the pavement (mm) and erm, but there was no immediate danger they had gone, they had done what they meant to do and I, there was no feeling of anxiety, one of enormous anger, one of enormous sadness but but not at any anxiety (mm) what had happened had happened. The one, exa, and that, that was in Londonderry now in Fermanagh, five, no four years before that (mm) erm we had very rudimentary radio control systems and the IRA were very good at planting bombs that were set off by remote control and we had just, at the advent of the at sort of campaign, we had designed systems that would block either block or tell you there was a radio attack happening (mm) and we had been sent out to look at a culvert where there was a very large device and one of my guys, well there were about four of us wearing this gear designed to, one of them was designed to tell you when you were under attack and it was all very rudimentary, we have much more sophisticated systems now, and one of these things was going off and we knew that we were potentially sitting right on top of and someone was actually doing that (indicates depressing a device) pressing a button and you don’t know where they are and you don’t know where the device is, but you do know someone’s trying to actually get you and you think “My God!” that was actually a moment of you know.” William, 2:15-3:11

In William’s example above we hear an account of a stressful time which includes a variety of information which deviates from a chronological account of the event. William not only includes information about the event, but also adds historical details and also reflects on the situation once it has passed. As William describes the event, he becomes personally involved in the retelling of it, going so far as to act out various physical elements within it to further illustrate the description he is providing verbally.

3.2.2.3 Figures of Speech

One analysis cue that I was looking for was figures of speech (FOS) and I was struck by their frequent use in the veteran’s discourse and so they appear as a repertoire in their own right. In addition to noting various FOS, I highlight two types of FOS in particular: ‘Gallows Humour’

(where it is spoken about as a subject) and the phrase 'you know', both of which appeared in various interviews.

Figures of speech appears in the personal/subjective group as the choice of using figures of speech in discourse demonstrates a divergence from the objective and reflects personal choice. This repertoire includes figures of speech which appear to come from the military or might reflect other aspects of their backgrounds (for example, upbringing, education, family and post-military life).

Gallows Humour is the phrase given to jokes made at times of intense stress – often when a person is facing death. Freud considered that people used gallows humour to avoid addressing the reality of situations and provide themselves with light relief (Freud, 1927). There appears to be an understanding of its role in military life as a process in the interviews and its terminology is also an indicator to the listener that humour has been used in stressful times the interviewees faced. I took the impression from the veterans that there was a distinction between when they used 'gallows humour' in their time in the military to the humour which might be used in civilian life. There seems to be an expectation that the level of humour would not be acceptable in civilian settings and the function of talking about it is to position the military humour apart from civilian humour. Modern-day military gallows humour is available in current literature available such as Nugent (2008) and Smiles (2011).

The phrase "you know" is used countless times in the interviews and I have been reflecting on its use in modern parlance. The Online Urban Dictionary describes many usages for the phrase including: You should know!; Do you think you understand?; Agree with me!; Are you listening?; I can't remember it but maybe you do; I can't say it; Complicity; and Implicitly. (Urban Dictionary, 2012).

Examples of figures of speech:

"to have a stiff upper lip" – George 6:10

"I think there is the sort of gung ho, I'm invincible, elixir of youth" – George 7:5

"bulldog resilience spirit" – George 6:6

“it’s this British bulldog” – George 8:2

“excuse my expression, when the shit hits the fan” – George 8:4

“earn your spurs” – George 8:22

I have included these particular FOS as they all contain a military theme. It is sometimes possible to trace these FOS back to military culture and institutions and indeed, there are books detailing phrases such as these for the leisure reader (Rottman, 2007; Hunt and Pringle, 2008); Robson, 2008).

Examples of ‘Gallows Humour as a subject

“the black gallows humour of the soldier which you would only understand if you had been through what we have been through” – George 16:17-18

“to be able to laugh and to be able to, laughter and fear are very close at that point but to be able to laugh and see the funny side of a very desperate situation, the gallows humour, we call it” – George 16:18-20

George mentions Gallows Humour twice in his interview, describing its use in difficult situations and also distinguishing it as something particular to the forces, as if a civilian would not understand the humour.

Examples of ‘You Know’

“people would just go and talk to him, you know, about their cousin’s problem which obviously it wasn’t” – Jack 7:7-8

“that was when you thought, I could really do with a double gin and tonic now, that was a bit hairy, you know” – George 1:15-16

“it’s like being a parent, you know, always putting your children first, you always put your soldiers first” – George 6:7-8

“one of my soldiers in my company was shot dead outside our barracks and I went out to see him and you know his brains were all over the pavement” – William 2:16-17

“you don’t know where they are and you don’t know where the device is, but you do know someone’s trying to actually get you and you think “My God!” that was actually a moment of you know” – William 3:9-11

“I just simply don’t understand the point (mm) of blinking off and feeling sorry for yourself about something that never happened (mm) what’s the point (okay) you know I think, you know there’s an element of how shall I put it, the stiff upper lip that is extremely valuable” – William 4:14-16

“so I I would almost say that my stress decreased somewhat once they left the base because I knew that at that point, you know, they had as much as they, I couldn’t do anything about it at that point” – Alfie 2:12-14

“Afterwards I said to my boss, well I said look, I think we made a mistake, you know (pours out water into glass) I think we could have found that and he said, he said, well, not quite shit happens but you know, but at the time we didn’t know the guy had died” – Alfie 3:31-33

“I don’t know, you know” – Alfie 6:17

There were so many examples of the veterans using this phrase, ‘you know’. The phrase was used to serve many different functions such as Jack 7:7-8 – indicating information he wanted me to know – whereas William 3:9-11 includes a final ‘you know’ where he is possibly trying to avoid saying something he finds uncomfortable.

3.2.3 Exclusive

The exclusive group of repertoires are concerned with highlighting a separation, or difference of the military from civilians. There is a perception of them and us in various analysis cues

used. In the lexical choices that are made, there can be specific military terminology, including acronyms which are not widely used outside of the military, might be used, which needs to be clarified by the listener to fully comprehend what is being said. Also, the oral delivery can provide the sense of difference fast delivery of words, particular tones used and words emphasised which reflect difference. There can also be the impression left on the listener of the role the interviewee is taking in saying things to them.

The repertoires in this group are:

- Derogatory
- Difference
- Distrust
- Directive

3.2.3.1 Derogatory

The first repertoire in this grouping is based on my interview with one particular veteran. Both on being present in the interview and on listening to the recording since, there was no mistaking the tone William used in parts of the interview as well as noting his choice of words and the positioning of these words in his sentences. I have named this repertoire derogatory, or patronising, because this was the effect of the discourse on me – to feel that the speaker was being derogatory towards me – patronising me – separating himself from me.

Here are some examples from this interview:

“I would suggest really strongly that you read ..” – William 6:7

“that’s a very odd, well yes, I think that’s a very odd way of putting it” – William 9:10

“it would be a very foolish person that says they went out and did all these things” – William 10:22-11:1

In William 6:7, there is a verbal direction to me – to read something. There is also, indicated by the choice of words “suggest really strongly” an implied suggestion William expected me to

already know about this and the fact that I don't could be seen as ignorance on my part of which William is patronising about. In William 9:10, is derogatory about the way I have tried to explain something by implying that it is odd. However, instead of attributing the oddness to me, instead of using a personal pronoun to attribute the explanation, William separates it from me to an impersonal pronoun. Both the choice of word "odd" and the tone used, indicate a direction of his meaning. That is, he means me to understand that he is being patronising to me, without being explicit. In William 10:22-11:1, there is even less implication as he describes 'a foolish person' although, again, this is not directly attributed to me but is 'heard' by me as such.

It is necessary to consider William's use of the derogatory repertoire at a deeper level, in trying to position himself in a different place from me. Is it possible that he is trying to avoid talking about something he finds uncomfortable and therefore tries to impose a barrier between himself and me so that I am less likely to pursue asking him about difficult issues. Alternatively, he might be distrusting of me and keen to maintain a separateness and protect himself from being too open with the interviewer, by patronising the interviewer, the participant can create a separation.

3.2.3.2 Difference

The second repertoire, difference, considers terminology used in order for the interviewee to position themselves in relation to others. In the military, there is a wealth of terms which have been constructed to convey difference. From the simple difference of designation of 'soldier', 'sailor' and 'airman, to the multiple layers of designation - – troops, brigades, ships, bases, regiments, commissioned officers, (or COs) as opposed to non-commissioned officers (or NCO's, or squaddies, as per the colloquial term), the terminology can be used to designate, but it also provides a measure of difference by language. This is then further extended to highlight the difference between the services of the Armed Forces and civilians, when the terms are unfamiliar to the civilian listener.

Examples from the interviews include:

*"all the command structure, the co's and nco's, sergeants and warrant officers" –
Joshua 7:3-4*

“but there were probably fourteen second lieutenants in the battalion of whom ten were national service men” – Joshua 7:17-18

“I remember saying to my, to the company commander, he wasn’t my company commander” – George 4:6-7

“silvery-tongued Oxford and Cambridge trained barristers” – George 12:8-9

The first three examples all relate terminology used in the military and indicate difference either through rank, through commission type and through difference in regiment. The last example, George 12:8-9, shows a negative difference between military personnel and civilians. His description singles out a particular professional group, attaching an identifier of their origins as well as a descriptor about them – silvery-tongued – which carries with it a negative view of the work they carry out. This negative view is an additional difference to the work George would have carried out when he was in the forces.

3.2.3.3 Distrust

At times during the interviews, I had the sense that there was a level of distrust from the veteran towards me, and this is the third repertoire in the Exclusive group. This repertoire was apparent in guarded language, the veterans correcting themselves and relaying new information in less negative words. This was also apparent in style: as an interview started, responses would often be kept to a minimum with little personal information offered – the choice of professional language, the tone, the delivery; however, as the interviews continued, these elements changed and as more personal information was offered, it seemed to me that the sense of distrust possibly experienced by the interviewee reduced. Tones of language became warmer, there were fewer corrections and the person’s “voice” could be heard in what was being said, rather than the “voice” of the military person they were once were.

To illustrate this distrust repertoire I have selected two sections of the transcription of Oliver’s interview. The first section is right at the start of the interview:

“Er stress would be, um a both a physical in terms of tiredness, erm a and putting yourself in a position where you find it difficult to function, erm physically, erm because of either the hours or the tasks that you are being given. Errrm, which would then create a degree of, erm, mental uncertainty that would lead to, er, a difficulty in being

able to contemplate continuing a task and or being able to think about what you've done sensibly afterwards, erm. Mentally, umm, being able to cope with the information you have been given and being able to come out with a sensible option. Erm, specifically, as an officer, being able to ensure that there is a safety of your team is paramount and being able to cope with the task. And when I say cope I mean an ability to make sure that one, you get through it, two, you achieve it er, and that's from your service. In a general training environment, the stress is the ability to succeed and complete the tasks you are given so you can move forward without either having a sense of failure or, in fact, therefore losing your job, erm." Oliver 1:5-14

The tone is brisk; there is little reference to personal experience and the response seems to be detached. By contrast, the second example, from near the end of the interview with Oliver, is more leisurely – the timing suggests a more contemplative response and the use of personal pronouns indicates the speaker is prepared to speak with me about personal issues as well as use of more colloquial terms such as “basket case” which might have been avoided if the speakers was trying to convey a professional tone rather than a personal one – a lowering of distrust:

“A huge sense a reticence, because I would have felt I would have been in a position to , er, have put myself out to what we would have called a “basket case” er and therefore wouldn't have used at all. Knowing what I know now, it would be a lot easier to deal with it and talk through it but that needs to come partly from the medical authorities who were poor and should have had some of that inbuilt into what they were doing, to, to, to pre-allieve, right this is what you are going to feel when this happens, don't worry about it, it's normal. You need, you're working to get yourself well, therefore, yes, you are not letting anyone down, this is absolutely normal. Everyone understands this is the case, but at the time if anyone said do you want to talk about this, I would have run a mile. Because of that reticence of being seen as not mentally strong enough.” Oliver 17: 6-13

3.2.3.4 Directive

During the interviews and on listening to the recordings, I sensed that some of the veterans were placing themselves in the role of teacher or information provider – being directive with their information. The fourth and final repertoire in the Excluding group is concerned with how the discourse indicates the positioning of the interviewee. The directive nature of the

discourse places a sense of difference between the interviewee and the interviewer – that the interviewer should learn something that the interviewee considers necessary.

“there’s a couple of things ... you might look at” – William 6: 21

“it would have been the people in the battle group who would go out and do the operations based on what I thought was the risk” – Alfie 1: 25-28

William 6:21 is straight forward in telling me to research a couple of areas that he considers would be important for me to study. Whereas someone might use suggestive language, William’s choice of language is to the point and makes me consider him in the role of a lecturer who is instructing his class on pertinent issues.

3.2.4 Mind-Body Connection

This group of discourse repertoires is concerned with the link between mind and body – expressed both in lexical terms as well as non-verbal communication during the interviews. The group includes

- 3D (Physicality),
- Defence Mechanisms,
- Disturbed,
- By Design and
- Dependability.

3.2.4.1 3D (Physicality)

The first of these, the 3D (physicality) repertoire occurs when the veterans choose adjectives indicating the physical effects that stress and resilience have on themselves. The choice of title for this repertoire reflects my thoughts on hearing these definitions which made me consider how stress might exist if it were a 3D concrete construct rather a lexical abstract construct. These adjectives appear to take on the mantle of metaphor and simile: body strength for resilience and physical exhaustion for stress. For the listener, these constructs, in

terms of their cognitive and emotional effects and affects seem to provide a lexical picture of a physical experience.

The following are examples of this repertoire:

“stress would be, um, a both, a physical in terms of tiredness, erm a and putting yourself in a position where you find it difficult to function, erm, physically” – Oliver 1: 5-6

“trying to keep fit and strong the whole time” Oliver 5: 8

“resilience is the ability to deal with situations which at time you don’t think you can cope with erm, bringing it back to basics, whether that’s physical or mental” – Oliver 2: 1-2

“it’s often when you came back, you felt exhausted because suddenly you had this come down” – George 13: 10-11

“we would be hit if we got things wrong, a clip round the ear with microphones and hit with parallel rules, erm and that was quite stressful and I almost resigned over it and then one day, not deliberately, I just practically stood up to him and there said don’t ever come near me again” – Jack 1: 14-16

Oliver’s examples include the connection between stress and the physical and he equates stress to trying to maintain physical fitness (Oliver 5:8). George is less direct about the physical connection, although by connecting exhaustion to stress, there is an implication of the physical nature of stress (George 13:10-11). Jack’s example is one of a physical event which he equated as being stressful – rather than an event being psychologically stressful.

3.2.4.2 Defence Mechanisms

The second of the repertoires in the mind-body connection group is defence mechanisms into which I am including ‘gallows humour’ as a process. The term defence mechanism is well known in the psychodynamic approach. Using such a familiar term as defence mechanisms may be the cause of some confusion, but here I am using it to describe incidents whilst the veterans

speaking which appear to be mechanisms that help them to defend against the stress of what they are talking about or thinking about.

Here, as a discourse analysis repertoire, I have broadly split this repertoire into two camps: firstly, non-verbal interruptions or additions in the course of speaking about stressful events experienced including yawning, tapping the table, taking a drink, audible breathing in and out that is more forceful breathing than would currently be required whilst talking. These cues are often the body's way of indicating both to the speaker and to listener the physical effects the subject matter being spoken about is having on the speaker, let alone the listener.

Gallows humour as a process is included as I noticed the interviewee would interject humour into his discourse with me – indicating the process of gallows humour in the moment, rather than talking about it as a subject. The function of this type of discourse, which would be recognised as gallows humour, disrupts the potentially stressful subject matter being discussed, and is stylistic. In addition, there is also the occurrence of lexical choices which do not seem to fit the theme of the content being discussed – for example, using the word “funny” after speaking of a difficult situation.

The following examples show these types of defence mechanisms:

“and you think about how you extricate yourself (exhales/yawns)” – William 3: 22

“we can't sit here shitting bricks . . or we will be toast . . phoof, bang, gone (laughs)” – William 11: 19-20

“and they would shoot one of the protesters (laughs) that was they used to do then (laughs)” – George 3: 13-14

“I might have been six under, mate, six foot under, so, oh, oh, you, ohhh (exhales) – George 4: 11-12

“you could feel the hate, you could almost smell the hate, the hate was unbelievable (laughs)” – George 5: 8-9

“the IED went off, which, (breathes out) was in the area and actually when you went back and looked at the message, I don't know what we had done wrong, but we had

made a mistake somewhere and er (breathes out) (pause) and we hadn't been as accurate as we could do with these guys. So they didn't find it and it then went off against a vehicle and some people, well, someone called, some guy was er injured and then (breathes out)" – Alfie 3: 15-19

"I thought, phew, the guy's going to fucking survive (breathes heavily) erm and the guy dies" – Alfie 3: 22-24

"look, I think we made a mistake, you know (pours water into a glass) I think we could have found that and he said, he said, well, not quite shit happens, but you know, but at that time we didn't know the guy had died" – Alfie 3:31-33

"well, er, you know (breathes in and out) erm, I haven't really thought about it to be fair . . . well, there are lots of people who have got a lot more to think about that then that, well (knocks table with hand) I just don't talk about it" – Alfie 4: 3-5

"(purses lips/intakes breath/squeaky noise) (pause) erm, I suppose, (pause)" – Alfie 1: 13

"I think it was just personal pride (clears throat) that I would finish what I had started, no matter what" – Jack 3: 9

"er (clears throat) I was very miserable" – Jack 2: 10

"then there was an accident on board his ship caused by him and he walked off and so it didn't help him it got worse and worse (finger tapping on table throughout) – Jack 9: 4-5

"we arrived in Cyprus, we knew people were being shot at, we knew some soldiers had been killed and off you went (laughs) company commander says good luck, almost good luck old fellow . . . funny" – Joshua 7:11-13

"I felt I wanted someone else's opinion on this, I am (opens water bottle to pour into a glass) I haven't been here before" – Joshua 3: 7-8

Each of these examples were 'in the moment' defence mechanisms in action.

3.2.4.3 Disturbed

Although some of the participants had an undisrupted speaking style, for others there was what I am calling the next in this group, the disturbed repertoire which was apparent in the interviews. This was particularly noted when the veterans were talking about or were asked to think about stressful times. Their speech, instead of following a “smooth” path in telling me information, became jumbled, often changing direction and even changing subject whilst in the same sentence. In contrast to the defence mechanism repertoire, where the mind-body link comes out in physical interruptions, the disturbed repertoire is where the interruptions come out in the flow of the discourse with corrections, hesitations, repeats and inconsistent construction of sentences.

The following illustrate this disruption repertoire:

“no, no, not er particularly er ah I had a couple of when you say anxious as being frightened, yuh” – William 2: 8

“And it was a dangerous environment but I don’t think cos I was we were getting bombarded every day, but I never actually apart from a couple of occasions, I never actually felt scared of the environment itself” – Alfie 1: 20-22

“but I, er, it was sort of, build up, I er” – Alfie 2: 5

Both of these veterans had been articulate in their speech styles so the examples above a clear example, with interruptions and corrections happening frequently throughout, of the disturbed repertoire.

3.2.4.4 By Design

The By Design repertoire represents a function of the speech of the participants. I noted in some explanations or descriptions, rather than describing themselves as actively engaged in coping with stress and resilience, they provided responses which suggested the opposite – a subconscious or automatic reaction to stress. In terms of the mind-body link, this kind of automatic, physiological response would correspond to the body going into “automatic pilot” linked to the human reaction of ‘fight or flight’. The positioning of their response to stress also highlighted the conditioned learning of exercises within the forces so that responses to situations do become automatic. In particular, in relation to analysis cues, I found that

particular words were used such as “automatic”, “conscious” and “trained”. The following examples from the transcripts illustrate this repertoire:

“you never know how you are going to react, you never know if you are going to be brave or not ... and then it’s not a conscious decision, or at least it wasn’t a conscious decision in my case” – Jack 3:16 – 4:1

“and when we were being attacked, I don’t think oh gosh, I’m alright, I was just doing my job. And so to me that, that meant I must be quite resilient because I didn’t, I wasn’t affected by it” – Jack 4: 3-4

“they put you under pressure to make sure you, you learn your job” – Jack 4: 11-12

“on a couple of occasions yuh I was very frightened but that simply doesn’t come into play because you are so busy concentrating, working out what to do” – William 2: 9-10

“that {being shot at} focuses your mind like nothing else (mm) like nothing on earth and there is not training at all that can compensate for that (mm) and the certainly you are trained to be extremely well drilled and extremely well organised and that just often kicks in and becomes an automatic response, a Pavlovian response I think that’s incredibly important because that does all the fears that people have” – William 11: 12-16

“resilience, erm, I had this automatic resilience that I think most people have, that clicks in due to the training . . when you are too busy to worry about yourself” – George 1: 7-9

“erm, resilience, resilience (pause) I don’t know, I just go back to the British Army, well-trained” – George 6: 5

“I dealt with it {stress} by trying to make sure that the mechanism we had in place we weren’t missing anything” – Alfie 2: 18-19

“we went off and did what was asked to, to do so I don’t think we felt invincible, we just got on with it” – Joshua 7: 20-21

“it sounds like a lot of training and it’s not specifically using the words that I’m using, resilience training, but it’s all adding to this being able to be resilient in the face of difficult situations” – Joshua 11: 17-19

In performative terms, the examples above represent a passive view of resilience rather than a construct which requires specific activity apart from following orders and training previously given, almost as if the person does so without questioning.

3.2.4.5 Dependability

When asked to describe resilience, I was struck by the frequency of terminology used by the veterans which suggested the extent that dependability was required from them to their colleagues and by others to them. In using this word, dependability - the last of the repertoires within this group - I am aware that this could be interpreted as a content theme rather than a discourse theme. In terms of discourse analysis, the cues I particularly note are how the lexical choices enhance the descriptions of dependability (for example familial terms) indicates the role taken on by the person and how these roles are communicated to me, as well as the emphasis in tone and repetition of words to emphasise points being made.

I have placed this repertoire in the mind-body connection group as it seems to me, upon hearing about the closeness developed between each other due to dependence, that the people they serve with are seen as an extension of themselves; a mind-body-other body connection, as it were. This seems to reflect an internalising of the others into their view of themselves.

Here are examples from the transcripts which illustrate this repertoire:

“it is the organisation that surrounds you and envelops you, protects you from everything” William 1: 10-11

“you know they all work like crazy for each other” – William 5: 6-7

“bring them back to their friends as quickly as possible and to be and to surround them with an environment where their mates are and it is their mates that will, that

feeling of community, that feeling of regiment, that feeling of togetherness which is what will help nurture them back” – William 10: 17-20

“I mean I was bloody terrified on a number of occasions, I mean terrified and it’s about drawing on the strength of the blokes around you and I felt that was, that was very comforting, very comforting” – William 11: 3-5

“people have responded very well to being drawn together as a team, you know very much relying on each other, going well beyond the boundaries of some other” – William 13: 2-3

“as an officer you just can’t let your guard down, it’s the responsibility for other people, it’s like being a parent, you know, always putting your children first, you always put your soldiers first” – George 6: 6-8

“when the shit hits the fan you’re not fighting for your country, you’re certainly not fighting for the government, you’re fighting for the bloke there [points to one side of him] and the bloke there [points to the other side] cos you’re the guys who keep each other alive” – George 8: 4-6

“they looked after us like fathers in a way” – Joshua 7: 5

“your overall resilience is always going to be carried much more strongly if you’ve got a bunch of guys around you that you can actually rely on and trust” – Oliver 5: 15-16

“I was more worried about the crew” – Jack 2: 2

“we ended up at forty five degrees going straight towards the bottom . . and I could see everyone looking at me and I knew I had to keep a straight face” – Jack 5: 18-21

The effects of many of the examples is above is to recognise that being part of a group takes a greater precedence than recognition of the self, especially when under stress.

3.2.5 Refutation

The final group of repertoires comes under the title of Refutation. The repertoires are

- Denial
- Defensive,
- Downgrading,
- Personal Pronoun and
- Defective.

3.2.5.1 Denial

The first repertoire, denial, was named as such because for some veterans there was a challenge, a refutation that the word stress existed in their time of serving or was not in use, which might suggest lexical changes over time. In addition, some veterans also expressed an opinion that since they didn't experience stress, therefore it couldn't exist. Because of this, there was disagreement with the social construction of a word which, they believed, did not match a supposedly imagined experience. Also, in the choice of words and positioning of the self, there was a denial of the self within periods of stress.

Examples of denial are:

"we never even used the word [stress] when I served, it was, it just didn't used to exist" – William 1: 7

"they didn't have stress management during the second world war and they all seemed to cope with it pretty well" – William 8: 18-19

"the stiff upper lip .. is extremely valuable" – William 4:16

"having said all that, I am not a great believer in stress" – Joshua 1: 9-10

"it never occurred to us that it was a problem and I never saw it being a problem to anyone else" – Joshua 7: 7-8

"I don't think we felt any stress, literally, none, never occurred to us" – Joshua 8: 11-12

“it’s not something that stresses me” – Alfie 4: 5

“it didn’t really affect me” – George 6: 1

The denial repertoire features both a denial that the construct of stress exists (eg William 1: 7) as well as a denial of the experience of stress (eg Joshua 8: 11-12). Alternatively, denial can also be seen as a personal experience, although it might happen to others (eg George) whilst for others there is an active denial of stress in the moment, maybe to be visited later (eg Alfie) or to be sublimated by the ‘stiff upper lip’ (eg William 4:16).

As William uses the figure of speech “stiff upper lip” we see how it used to prohibit self-analysis. There is a sense that the negative feelings connected with anxiety or stress are not dealt with as they are too uncomfortable and so there is a denial that they should affect other service personnel.

This is also reflected in the tone with which words are spoken immediately afterwards, using a high pitch voice to consider a potentially anxiety-provoking situation, compared to the lower tone used for “stiff upper lip”. This could be considered to reflect a masculine, and therefore, by implication a strong response, compared to a feminine and therefore, potentially weak response.

3.2.5.2 Defensiveness

The second repertoire in the Refutation group is defensiveness. The tone of discourse in some responses indicated to me that the interviewee had taken a comment or question of mine negatively and their responses were defensive by return. The responses in this repertoire are not always explicit, their meanings often use tone as a discourse tool to imply a defensiveness. This repertoire is placed under the refutation title, as the interviewee appears to be refuting something I have said. As well as tone, other cues include a questioning style of sentence construction; repetition of words to indicate a refutation; highlighting lexical choices of the interviewer; and metaphors which include figures of speech such as ‘rough diamond’. In this the interviewee defends his men as he sees great quality underlying a ‘rough’ exterior. Here are some examples:

“I don’t know what er what do you mean by difficult times” – William 1: 15

“what typically might a difficult time be? – William 2:2

“why would you want to do that {reflect on a difficult patrol in Northern Ireland at the end of the day}? What’s happened, happened, you’re not going to change it” –

William 4: 13

“oh, oh, oh look, it doesn’t matter where the bullet’s fired from . . . if a bullet kills you, it kills you and that’s that, it makes no difference to you whatsoever” – William 5: 13-

15

“no, no, I mean, I er, you’ve latched onto the word shirking” – William 10: 11

“did I ever feel inadequate? No, not inadequate, I didn’t feel inadequate” – Joshua 3: 6-7

“rough diamonds are usually pretty good in the combat” – Joshua 22: 17

“well, anyway” – George 5:5

William uses the words he speaks to be defensive against me as to my definition of a “difficult time” rather than a genuine question of what I mean by the phrase – “what do you mean”, “what typically..”. The tone with which William delivers 4: 13, 15: 13-15 and 10: 11 implies defensiveness towards me, the listener/receiver of the statements. Joshua 3: 6-7 indicates defensiveness by associating stress with inadequacy and defending himself from the possibility that he might have been inadequate whilst Joshua 22: 17 uses a metaphor in “rough diamonds” to be defensive of his troops. In a very short quote from George, he indicates in his tone and in his choice of these words that he is in control of the discourse, not me and is going to pass on from what has been asked, producing a defensive change of direction as a result.

3.2.5.3 Downgrading

The third repertoire I have called ‘downgrading’. As with the dependability repertoire, this could be seen as a content theme as well as a discourse repertoire. In it, comparisons are made when considering stress experienced of veterans and current personnel. Including it as a discourse repertoire is because, it seemed to me as the listener that many of the veterans used this positioning after discussing a stressful time they had experienced and its use was to reduce or play-down any stress they experienced by the retelling of their experiences. It has

been suggested to me that this repertoire could have been titled 'minimising' to reflect the performative function of this repertoire.

These are examples of the down-grading repertoire:

"I still talk to some of the guys I know in the regiment in Afghanistan and of course it's ten times worse than it ever was for us . . . you know they have far far more dangerous situations don't they" – William 5: 8-10

"that [Northern Ireland crowd threatening to kill him and his patrol] was the most stressful thing I went through I think. But compared to what these young lads are doing now, it wasn't too bad" – George 4: 1-2

"well, there are a lot of people who have a lot more things to think about that than that" – Alfie 4: 5-6

"I was shitting myself at times you know but I never had really really horrendous things to see and deal with which I imagine a lot of other guys would" – Alfie 9: 1-2

"I probably didn't see it as stress at the time, certainly not compared to the people who were out on the front gates and facing these IEDs" – Alfie 2: 20-21

Specifically, in terms of discourse, lexical choices were laden with emotion; words are duplicated to emphasise dangers for current service personnel; the juxtaposition of phrases like "shitting myself" followed by "never had really really horrendous things to see and deal with" – contradictions in the middle of sentences; and uses of words like comparison to indicate an internal process for them.

3.2.5.4 Personal Pronoun

The personal pronoun repertoire (which could also be called distancing) was noted because during the interviews, I particularly asked the veterans for *personal* experiences of stress and resilience to see how they would position themselves within their accounts. The response was mixed with some using a first person pronoun to describe events, whilst others used either second or third person pronouns to illustrate their experiences. The pronouns sometimes changed within a sentence and there was also a mixing of singular and plural pronouns. When there was a change in pronoun use, or when the first person singular

pronoun was not used at all, the effect on the listener (myself) was that it seemed the veterans were attempting to distance themselves from the accounts they were describing. Because of this distancing themselves from the first person pronoun in their accounts, there is a sense to the listener of the interviewee refuting their involvement in the stressful experiences.

Examples of the Pronoun repertoire are:

“based on what I thought was the risk . . . you would slightly be guessing but you had to send people based on your conjecture” – Alfie 1: 27

“we did all the briefings and we went to get some sleep for about three hours before we all got to start the operation” – Alfie 3: 3-4

“and you just wonder if I had been more awake, if I had taken more time over it, if I had . . . and you understand that you made, a mistake was made” – Alfie 3: 25-26

“I can’t think of a specific occasion, it would be sharing with two or three close friends or guys you work every day with and, yeah, you just talk about it” – Alfie 4: 25-26

“I went out to see him, . . . I, there was no feeling of anxiety” – William 2:17-19

In the first three examples taken from Alfie, he resolutely uses pronouns other than the personal one. In his fourth example, there is a moment when he uses the personal pronoun before switching away from it. William goes further, by correcting his choice of words in the middle of a sentence, leading to a sense of refutation of the personal in the situations, in favour of a more collective position.

3.2.5.5 Defective

The final repertoire noted in this analysis is defective. As the veterans describe themselves or others experiencing stress, the choice of adjectives were often negative – Joshua uses words such as “inadequate”, “nutty” and phrases such as “not up to his job” as well as “very, very, very unpopular”. In addition, phrases were also negatively loaded - George describes those suffering from stress as the “weak link” and that they would be “wheedled out” whilst Oliver takes this theme further, when considering stress he underwent and tells me he was trying not to be considered as a “basket case”. Metaphor is used by Alfie when he talks of avoiding being

seen as “the wet or the baby”. The choice of words which William uses, when recollecting someone suffering from stress concentrates on the person being “very strange”, “completely off the rails” are all negative. He goes on further to suggest that only “turncoats” or “shirkers” would suffer from stress. These verbal cues are loaded with the meaning attached to the concept of stress for these veterans. These examples are more fully demonstrated below:

“that is stress (mm) so it’s a bit, it’s to me a bit of an all-inclusive word for not being able to manage” – Joshua 1: 15-16

“so it was, er, yes, only in those two situations did I ever feel inadequate” – Joshua 3: 6-7

“I have certainly known of inadequate people struggling” – Joshua 15: 12-13

“I had a man in that part of the chain who wasn’t up to his job” – Joshua 15: 17

“I know of another regiment near us where the CO went nutty and couldn’t handle the stress” – Joshua 19: 2-3

“I’ve known very, very, very unpopular people in the army” – Joshua 6: 17

“you can bemoan the characteristics of some of the guys around you who, who, who you would consider to be not be either physically in good enough shape or, erm, you, a little bit mentally soft” – Oliver 11: 8-10

“A huge sense of reticence, because I would have felt I would have been in a position to, er, have put myself out to what we would have called a “basket case” – Oliver 17 6-7

“I’ve heard of one bloke since (mm) who erm, well he was a very strange bloke . . . he went completely off the rails (mm) ended up being homeless” – William 8: 6-10

“there was never any question of any of them shirking or (mm) turning tail, none of that all” – William 10: 4

“you don’t want to be perceived as the wet or a baby” – Alfie 6: 27-28

“if they couldn’t have coped with it, most of them have been wheedled out, to be be honest, I think (mm), if that’s fair to say” – George 2: 4-6

“if you can’t do it and you’re going to let the boys down and you’re a weak link and you are putting others at risk, not for you” – George 10: 17-18

“I think we’re pretty good in our army at spotting them, the weak link! – George 11:

8

It could be considered that by using words that suggest people are defective if they suffer from mental health issues, that the veterans here are trying to distance themselves from these other people and would not want to be considered in the same as them.

4 Synthesis

The synthesis section is divided into four parts:

Part 1 - an examination of:

- Defence: The 'Unspoken' Discourse – a superstructure which I consider in relation to the repertoires discussed in the Analysis section.

Part 2 - findings of the repertoires and superstructure in relation to the following:

- Military Culture, including commentary on Foucauldian aspects of the research
- PTSD Symptoms
- Ehlers and Clark's Cognitive Model of Posttraumatic Stress Disorder
- Neuropsychology of Trauma and Associated Memory
- Dual Representation Theory

Part 3 -

- Suggested Practical Applications of Discourse Repertoires

Part 4 – examination of:

- Issues with the Current Research
- Building on the Research
- Reflections on the Research and Self

4.1 Part I:

4.1.1 Defence: The 'Unspoken' Discourse

Over the months I have had to consider the discourse repertoires, the theme of defence appears to impact or be impacted by each of the repertoires to some extent. The emergence of this theme of defence is more often implicit in what has been said so, instead of considering

it as a spoken discourse superstructure, I have viewed it more often as an unspoken discourse superstructure. In fact, the word 'defence' is hardly ever mentioned in the transcripts.

Discourse superstructures are described by Burr (2003) as the emergence of lexical constructs, following discourse analysis of transcripts, which seem to encapsulate the repertoires. The discourse superstructure provides a framework for each of the separate repertoires to be considered within as well as linking the repertoires. The emergence of a discourse superstructure is drawn from the researcher's interpretation of the repertoires and will be influenced by the researcher's social construction of themselves and reflects their motivations in the research. For myself I consider my social construction as including, but not limited to: doctoral student; counselling psychologist in training; worker with veterans; female; British; conservative.

In this research, each of the repertoires described above are not to be considered as exclusive to the military or to veterans, as they might be recognised in counselling sessions with a wide variety of clients from many different backgrounds, bringing many different issues in for consideration. What is particular to the veteran's discourses, however, is the discourse superstructure of defence which is implied in the way they speak about stress and resilience. These ways include: defence of their service; their actions; their regiments; their colleagues; and the conflicts they have been involved in. In addition, defence could be considered to be imbued in these people through different pathways including: through their training; through their colleagues; through their superiors; through the language that is used around them; through the culture of the organisation; through the requirements of their occupation; through the experience the immediate need to prevent one's own or another person's death.

In considering the theme of defence, looking at definitions, defence is a noun – meaning protection for someone or something, from or against someone or something. In order for the noun, defence, to occur, we need to defend – the verb. For example, in defence of our homes, we defend against floods. I have considered both noun and verb in the discourse superstructure to include the action of 'defend' with the noun 'defence'.

At the same time, the discourse superstructure is not just about the definition of defence and defend but is about the concept of defence. The overriding effect of the veteran's discourse was to suggest to me, the listener, the concept of defence, although in actuality this word was not used by the veterans in most of the interviews.

I have chosen three passages of speech from the veterans to illustrate defence as a discourse superstructure. I examine each section as if it were a process report, drawing out in each where I hear the defence discourse superstructure in operation. Although these sections are from three different veterans and are concerned with three different issues, I do not view these as autonomous but, instead, contiguous to each other.

4.1.1.1 Example 1 - Alfie

The first example shows how defence as a superstructure operated at an individual level, with the veteran defending himself, not only from an enemy but also from himself. He is protecting himself from the construct of stress which has a meaning of weakness, a means of stigma to him, as well as defending himself against someone else thinking he is weak.

The following extract comes from a section where the veteran, Alfie, has just revealed an incident he experienced which he has not spoken of since the official debriefing at the time of the incident. For the first time Alfie considers aloud, with someone other than his commanding officer, the events of one night whilst he was serving. This piece of discourse is like a spiral of words, possibly reflecting a spiral of thoughts running through Alfie's mind. (As he remembers the incident, it seems he is creating a picture of these thoughts in his use of words. His use of words seems to reflect the thought processes which may be occurring.)

As Alfie considers the events, the spiral of words he speaks seem to increase his awareness, possibly even his acceptance that he has experienced stress because of this event, something he seems to have been in denial about before. We see here, that as the revelation of stress occurs to Alfie, he resorts to a type of defence mechanism highlighted in the repertoires – the downgrading of his experience compared to others. The connection between his discourse to his thought processes, from a point of view which he would have considered rational, appears to lead him to greater realisation of the effects of the event on his thoughts and behaviour.

As this realisation occurs, and as he realises the extent he has been troubled by this experience, I sense that he has to find a way to defend himself – and he lets me know this by telling me he just doesn't talk about it further in no uncertain terms – “(*knocks table with hand*) *I just don't talk about it.*” – in order to defend himself once again.

Here is the passage of discourse:

“Well, er you know, (breathes in and out) erm, I haven’t really thought about it to be fair (okay) well, I think about it myself, it’s not something I lie awake losing sleep over which I wish I did actually, erm, but I do think about it, well not every day, but every month, but it’s not something that stresses me, well, it does stress me, but it’s not something that (pause) well I think about it, well, there are lot of people who have got a lot more things to think about that than that, well (knocks table with hand) I just don’t talk about it.” - Alfie

I picked this section because, as the listener, I hear a theme of defence throughout: *“I haven’t really thought about it”* makes me think he is defending himself from troubling thoughts as well as defending himself against me thinking of him as a troubled person; *“it’s not something I lie awake losing sleep over”* goes further to defend against me thinking it is an issue for him; *“which I wish I did actually, erm, but I do think about it”* – Alfie lets slip an admission of desire to think about the stressful time, or maybe a position of guilt and a desire to admit he got something wrong which ended with someone’s death which is then quickly refuted – defended. This sounds to me like he is trying to defend himself from me considering him weak in wanting to think about the situation.

Very quickly following this, I hear him saying *“but it’s not something that stresses me, well, it does stress me”* – and I am left wondering if this dual position reflects many in the forces who might say to themselves that they do not feel stress, but at some point recognise the reality of the stress they feel. I am reminded, through these words, of Burr (2003) who comments that *“the way we represent things to each other matters crucially”* (p43) – it appears to me that Alfie is ‘crucially’ concerned about how he is representing himself to me.

Alfie then changes the flow of the discourse by turning the conversation away from himself – *“there are lot of people who have got a lot more things to think about that than that”* – to consider defence for others. Turning the attention to others communicates to me a potential social practice from the forces which considers others first – where they must be defended ahead of yourself. The knocking on the table then enhances his words and adds to the discourse to indicate the finality of his defence of himself.

This discourse from Alfie shows the veteran defending himself and psychologists may recognise the way he is speaking as the type of discourse heard in the counselling room – not only in terms of content, but also in terms of intent.

4.1.1.2 Example 2 – Joshua

The next example is chosen to illustrate how, at an organisational level, the veteran defends their institution by rejecting criticism and refuting problems. The discourse superstructure of defence is implied by a need, or want, or desire to defend the service, regiment, troops from someone who might be considered hostile – not knowing about these institutions as an insider might.

(pause) I knew some officers who weren't up to their job (mm) and because the army was the army and because loyalty required it and to an extent, obedience required it, old fashioned words again, you got on with until you knew the chap was finish with you and then you all breathed a sigh of relief and er said he's gone er, I've known very, very, very unpopular people in the army (mm) in ranks probably just senior to my own who people were very nervous of dealing with (mm) but we took a deep breath and got on until the chap had finished his appointment and went onto another job. Er (pause) go back again, I don't think I ever saw anyone ever collapse under the pressure of their, I've heard of them, collapse under the pressure of their responsibilities (mm) I've heard of it happen in other regiments (pause) I really don't think I ever saw it happen in mine (mm) but then I would consider myself to be very fortunate, we had a very paternalistic regiment, the [...], in which I grew up in. – Joshua 6:14-22 – 7:1

I noticed a pattern in some of my interviews where the participants would be quite closed off when I asked probing questions to them, and it seemed that they were 'toeing the party line' in their answers at the start. Their responses would represent a positive view of military service which appeared to have no negative aspects to them. As the interview continued, this defence of the forces would start to dissipate and the interviewees would tell me of more negative aspects of service life.

In the passage above from Joshua's interview, having not recalled any negativity from his service, he did start to consider some less pleasant experiences. He starts by telling me of "some officers who weren't up to their job" and follows this quickly by telling me that the culture and tradition of the forces required them to work with these people: "loyalty required it and to an extent, obedience required it old fashioned words". There is recognition that these words and what they represent, from a historical point of view, underpin military service. Implicit in using them is a demonstration of how the tradition and culture of the military are defended by reasons of loyalty and obedience. I find it interesting to note that, despite someone not being

good at their job, they are allowed to carry on rather than being sacked. I wonder then, if the military feel a need to defend themselves against admitting that people who are not suited to forces work, have been allowed to join up. Jumping forward, a distinction is placed between those who do the job and those who were “very, very, very *unpopular people in the army*”. This negative way of describing someone who is not fulfilling their job role suggests a character flaw – being unpopular – rather than incompetence. This alternative way of describing someone could be viewed as a defence of the system which allowed this person in in the first place.

When Joshua says “*you all breathed a sigh of relief*” followed shortly by “*we took a deep breath and got on until the chap had finished*” this indicates to me how he defended himself against officers who were not considered suitable and then was able to relax the defences once the person had moved away. Inhaling and exhaling operate both on physical and metaphoric levels; inhaling indicates the person in defence of themselves, or of the situation they find themselves in, whilst exhaling is concerned with releasing oneself from being defended.

For me, this section of discourse becomes more interesting when Joshua defends his own regiment compared to others: “*I’ve heard of it happen in other regiments (pause) I really don’t think I ever saw it happen in mine (mm) but then I would consider myself to be very fortunate, we had a very paternalistic regiment*”. It appears that Joshua has a complete belief that his regiment was above others, looking after its’ soldiers as a father would. Here I consider some idealised way that one might view a father as behaving and wonder if the experience of being treated filially matches the ideal.

4.1.1.3 Example 3 – William

I wanted to find an illustration of how defence might be implied in on a conceptual level, where the veterans are defending the right for humans to defend themselves. This was harder to find as most of the questions asked were about the veteran’s experience rather than a discussion about the wider issues of stress and resilience in the military. In this section from William’s interview, towards the end of the interview, we are discussing whether the construct of stress occurred or whether the meaning has changed over time. We are discussing how people coped with the events they experienced in war and other conflicts in the past. Without naming the symptom as a PTSD one, I have been trying to describe how a veteran might experience a flashback. William expresses that he cannot imagine that experience and I suggest to him that his personality enables him to think forwards, not backwards and that this might be part of his resilience – his ability to keep going. Here is William’s response:

And again, (inhales) one often hears you know, well, you know let's let just keep looking forward, it's not as if you compartmentalise it. Put it in a box at the back of the head and you are sitting waiting like a time bomb waiting to go off. You know I don't that all of those veterans from world war two (mm) even remotely even considered it, it wasn't even on their radar (mm) they had a war to fight and they were going to lose a lot of men, and they did and a lot of men got very badly injured and a lot of men got killed (mm) but you know, it was either that or live under the bloody jackboot (mm, mm) so, I er don't think there were two million men, or however many of them came back from fighting those wars who were waiting to have these time bombs go off. I mean sure there were some, but in those days, they were much more resilient in terms just looking practically at, it's just looking at it practically (mm) and seeing it from a practical perspective rather than an emotional perspective (mm, great) erm (pause) I simply don't see, I cannot see what (inhales) and I have lots and lots of friends who who have seen some horrible things, some terrible things but they don't all sit there, when we get together, sobbing into their beer (yeah) they all get together and have a beer and shriek with laughter at what a fantastic time we had (mm) I can happily say without fear of er er er of that the hap, that the most t, productive and happiest time of my army career and probably my life was my two years in Londonderry. I mean it was phenomenal, I mean the feeling that you get coming away from that (mm) with your mates (mm) and you come away intact and you will have worked and worked and worked in some really difficult pl, situations, and you will have lost some people and there are some guys who get very badly hurt. But you come away from that, the strength of feeling, well these guys will be friends for life (mm) (inhales) and you just think I've achieved something there, I've really made a difference to there and we kept the peace and we put some bad guys away (mm, mm) and the couple of bad guys went west permanently (inhales) (yes) you know and you know, we did, we did we did a great job and I'm en, and the great feeling of immense pride far outweighs any of the nastiness, far outweighs it."

William 17:16-22, 18:1-16

This is a long passage from William's interview and one thing I immediately notice, which for me implies the defence of defence, is how little I, as the interviewer, have interjected any words into the passage of discourse. William speaks, unchallenged and defending the forces and himself as well as what both the forces and he have accomplished. The information he provides is about the right to defend oneself, for example against "the bloody jackboot" – the country has the right to be defended against a foreign force. He is defensive about Second

World War veterans who, in his opinion, did not suffer from stress, but took what happened to them without emotional processing. He is defending his view in this that historically people wouldn't have suffered stress but knew how to defend their selves. He then draws his conversation round to his experiences with his colleagues – that they don't express sadness in a weak way – “*sobbing into their beer*”, but defend themselves and “*shriek with laughter*”. Even after the events they went through, it would be negative to be emotional about their experiences. Rather, the culture is to drink and continue with gallows humour to defend themselves.

I would suggest the superstructure of defence is implied in the inability of this veteran to reflect, even years later, on the emotional aspect of experiences he went through. The veteran, in an effort to keep themselves from crying about their experiences, uses defence mechanisms to maintain their status quo, leaving a core belief of defence unchallenged.

4.2 Part 2:

4.2.1 Military Culture

I wish to extrapolate further on the concept of defence in the sphere of military culture and also consider the Foucauldian aspects of discourse superstructure. In the methodology section, I discussed why this research was not being conducted with the Foucauldian type of analysis. However, I recognise here, by its very nature, defence is inextricably linked with power and to ignore it's importance would be foolish. Language presents and represents various power positions and the producers and listeners of these discourses understand the power flow implied in the discourse. At a macro level, the Armed Forces are in existence to defend the country and therefore, by role, hold physical power over the rest of the nation and against those who would seek to threaten the country. In addition, the Armed Forces through their hierarchical structure exert power on their own members. Even the names given to the positions held within the forces suggest power: captain, commander, squadron leader. The use of technical language by the Armed Forces excludes outsiders from a full understanding of what is being talked about and so the Forces place themselves in power over those who don't speak the same language.

Taking into consideration the issue of power which is represented in the construct of defence, I suggest that through language, the nature of the work and the culture of the military, it's members will have implicitly understood that they held a degree of power: through personal physical strength; through knowledge and capability of using instruments which could cause

death and destruction of property permission in conflict zones; through permission to kill other human beings. The reverse of this power is that military personnel accept they may be killed due to their occupation. If I use a CBT construct of core belief, believing something to be true about oneself, it could be seen that those in the military are taught a core belief that they must defend themselves and others around them, and have the mechanisms to do this, otherwise they might die. On leaving the forces, these requirements of their employment are no longer afforded to them as civilians; whereas they may have once considered themselves in a powerful position, on leaving the forces, this power is removed from them. Along with leaving the forces, the previously held core belief now needs to be amended in order to transition between military and civilian life.

If we consider a traumatic incidence takes place, possibly where the veteran has been injured or faced the potential of death, maybe causing them to leave the services, or where they have not been able to save someone from death, I hypothesise that the core belief of the power they held would be further challenged. Taking the hypothesis one step further, if the veteran comes into counselling, the psychologist is faced with someone for whom the power balance is further exacerbated due to his core belief of power, now powerlessness. By this I mean the veteran may now view himself in a position where he is now the person being defended (by the psychologist), rather than the person offering defence. And this change and difference in power positions is possibly no more apparent than in the language that the two people use. The psychologist is not speaking his 'language' and this alienation might lead the veteran to abandon the counselling room and his sessions.

The issue of the balance of power within the counselling room is a familiar theme for the psychologist who will be aware of how it influences the process of counselling. Where an imbalance is perceived, the threat of therapeutic rupture is greater. If, however, the balance of power is seen to be equal between client and psychologist, counselling is more likely to be experienced as a collaborative process.

I, therefore, suggest, in order for the psychologist to convey equality in the counselling room, language will be key. How to do this? After continuing to examine the repertoires in relation to military culture, and then neuropsychology and memory processing, highlighting key areas which I suggest are important for the psychologist to consider when working with a veteran, I will then look in greater depth at the repertoires described in the analysis section and, humbly, tentatively, suggest ideas for the psychologist if they recognise any repertoires being used in the counselling room.

In this section regarding military culture, I propose that as long as the language used by those in the Armed Forces conveys stigma towards mental health issues and those suffering from them, which I believe is demonstrated in the language of the veterans I spoke with, the culture which encapsulates that view will also remain. If the language used holds less negative connotations for mental health issues, and instead the issues are reframed in terms of memory processing and functions of the brain, there may be less stigma in mental health issues in the forces.

Using statistics from the Hoge et al. (2004) research about barriers which seem to exist regarding American servicemen seeking help with mental health issues, I was interested in the statistic that 59% believed their colleagues would not have confidence in them if they disclosed an issue, whilst 63% believed they would be treated differently by their leaders. Mindful that this study is based on American forces that have different cultural influences than British troops, I asked the veterans to provide a personal comment on this issue whereupon Joshua and George considered people who would report these issues as “inadequate” and a “weak link”. However, Alfie commented that, when considering personal stress, he “would be very keen to make sure nobody could perceive any signs within” him.

Interestingly, a study from Inbar et al. (1989) showed a “relative tolerance” (Inbar et al., 1989, p215) on the part of Israel Defense Forces commanders towards their troops who were displaying negative reactions to combat situations, especially when the people had been injured or were of low rank or displaying depressive symptoms. Conversely, Cawkill (2004) found that for UK forces, there was little support from leaders and colleagues to officially report mental health issues and minimal training at the time to support staff.

The issue of stigma in the military has been examined and researched in the UK (eg Gould et al. 2010; Gould et al. 2007; Iversen et al. 2011; KCMHR, 2010) and is acknowledged as an issue. Langston et al. (2007) examined the culture of the UK military and discovered there were significant cultural barriers still existing in the forces which meant many would not consider reporting issues detrimental to their careers. Although Greenberg et al. (2007) agreed that a high percentage would not report issues, they examined the attitudes of Royal Navy personnel towards colleagues experiencing stress and reported generally positive attitudes to this issue.

In considering stigma in the military, it is perhaps not surprising, that when asking my participants to provide a meaning of stress, some of their results indicated that stress was a defect in a person's character – an inadequacy – and that “real” service personnel would not suffer from stress – only the defective ones. This use of negative adjectives about these people would seem to reflect this negative culture. As long as this negative language prevails when considering stress or mental health issues, it will permeate not only their own self-perceptions of mental issues but also those around them.

Both Langston et al. (2007) and Cawkill (2004) discuss the need for the introduction of a new culture within the military which does not negatively consider mental health issues, and this is also important in the counselling room. In terms of discourse, does this change in culture occur because of attitudes or due to language changes? Burr (2003) suggests that culture changes occur due to changes in language. So, following on from this social constructionist position, in order for change to occur, the construction of the language would need to change in order for the culture to be influenced. Following on from my initial proposal at the start of this ‘Military Culture’ section, I would further propose that if the discourse regarding mental health issues is altered, so that a more positive position is reflected in it, I believe this could help reduce the stigma attached to the issues. I will discuss ideas for researching this proposal later in this synthesis section.

4.2.2 Masculinity

As well as considering how the culture of the military may be reflected in the language expressed by the participants, there is an underlying concept - masculinity, and in particular, its connection to the military, which must be considered. From a social constructionist viewpoint, we create understanding of our world around us by constructing meanings and concepts from a global level, to national to local, and finally to the personal level. At the global level, we make explicit and implicit distinctions between male and female; masculinity and femininity; gender differences. From the point of carrying out discourse analysis, it is not the content-driven words which are spoken, but the process-driven language which needs to be considered in terms of gender differences. In particular for this study, as all participants were male, the issue of masculinity needs to be kept in mind when considering the repertoires discovered.

From an evolutionary point of view, the physically stronger humans would have been involved in defending the group. As the physically stronger gender in humans tends to be masculine, it

could be hypothesised that it was imperative that, in order to maintain their position within the group, the males needed to perpetuate a 'strong' character. If this hypothesis is examined in relation to the military, descriptor words such as strength, protection, fighting come readily to mind, and these lexical choices could be viewed as both about defence and masculine. The opposites of these words – weakness, protected, surrender – might be more readily applied to the female gender.

In addition, it has been suggested that the nature of the military has masculine underpinnings in its very existence in the sense of using physical aggression to resolve conflict. Attached to this is that masculinity of the military culture might be considered in relation to concepts of heroism, killing and a need for emotional dampening. Although this study considers stress and resilience which could be constructions which are gender neutral, the repertoires expounded could suggest they are underpinned by masculine bias. That is to say, certain characteristics are expected from members of the armed forces and because of this, the repertoires discovered could be seen to reinforce this notion.

An example of where the perceived view of masculinity might lead to a disabling of talking about emotions could be a factor in the professional/objective repertoire or the distancing repertoire, as discussing emotions may be seen as a weakness, not masculine, and so language is amended to avoid a non-masculine position. In listening to the way stress and resilience is spoken about, seeking to uncover where the person is trying to defend themselves, might highlight masculine repertoires which need to be challenged. Although they may have assisted the person in getting their job done, the denial of the self and covering up where things are not working okay, could be challenged so that new repertoires are developed.

4.2.3 PTSD Symptoms

I would like to reiterate, before writing more on this section, none of the veterans who participated in this research had been diagnosed with PTSD. I say this here since I am not ascribing any of their words directly to the criteria for PTSD as described in DSM-IV TR (APA, 2000)(Appendix A). However, I was struck that some of the repertoires which have been noted might be considered pertinent to the criteria. As such, highlighting them might be useful for counselling psychologists to consider in the therapy room.

In addition, it is important to note that the percentage of veterans who have symptoms of PTSD represent only a small proportion of those with mental health issues, in line with non-military populations. Symptoms relating to depression, anxiety and substance disorders are more likely to be present. However, if the veteran has been directly involved in a trauma, the possibility of symptoms of PTSD does arise.

With reference to the criteria listed by the DSM IV-TR, I am going to draw upon the repertoires and consider how they might be used in recognising the symptoms listed in the criteria and help with treatment plans. In the first instance, many of the veterans interviewed for this research reported facing events which would be considered traumatic (A1) but few reported symptoms of horror or fear for themselves (A2). The direct and debrief repertoires would be important ones to utilise for details of events as well as the descriptive repertoire. With regards to A2, the mind-body connection repertoires might indicate if a veteran is finding the recall of these events stressful in the retelling.

For the criteria in section B, the disturbed repertoire, where the veterans' speech style is interrupted, and the defence mechanism repertoire might be apparent if they are re-experiencing the event in some way on a regular basis.

Section C criteria, where the veterans' accounts of the trauma are incomplete, would coincide with the details, descriptive and direct repertoires being absent. In addition, one interesting repertoire to question the veteran about would be if the dependability repertoire is present. On closer examination, the veteran may still want to believe in the concept that defence of each other will prevent injury or death. Where such an event has occurred, and the previously held construct is challenged, as discussed in the superstructure above, the veteran may still talk about dependability. However, when questioned if they still maintain contact with their old colleagues, there can sometimes be the admittance that they have cut themselves off from those colleagues. This relates to criteria C5 where people can isolate themselves from others, exacerbated by feeling detached or estranged from those they know and without an inclination to meet up with others. Where there has been incomplete or halted processing of traumatic memory, instead of the veteran speaking about their dependence on each other, their terminology might reflect their isolation rather than camaraderie, or a propensity to rely on themselves rather than on others.

Other repertoires to listen out for which connect to criteria in section C are the refutation and mind-body connection repertoires. These relate to avoidance of anything to do with the event, including denial of stress and efforts to minimise the effects of the trauma on them.

The last section where the repertoires might be apparent are D – the arousal criteria. Again, the mind-body connection repertoires should be considered here as well as the refutation ones.

4.2.4 Ehlers and Clark's Cognitive Model of Posttraumatic Stress Disorder

As discussed in the introduction, Ehlers and Clark's model of posttraumatic Stress Disorder provides a useful framework with which to understand the processes at work when someone is faced with a trauma and develops PTSD. I argue that some of the individual repertoires drawn from the analysis might be associated with some of the different elements of the model. In addition, I propose that the defence superstructure of this research is concerned with the 'strategies intended to control threat and symptoms' section of the model (p.321). These suggested associations are shown below:

Elements from Ehlers and Clark (2000) Cognitive Model of PTSD	Suggested Associated Repertoires
Cognitive Processing during Trauma	Direct Details
Current Threat Intrusions Arousal Symptoms Strong Emotions	Disturbed Defence Mechanism
Strategies Intended to Control Threat / Symptoms	Defence Superstructure Gallows Humour Downgrading Dependability Defective Denial Personal Pronoun

The Direct and Details repertoires can be seen as indicators of cognitive processing during traumatic times. In the interviews conducted for this research, the participants demonstrated

through the direct and detail repertoires an ability to process information received under stress without interruption and provided a clear and concise account of what occurred during those occasions. When these repertoires are missing, when the client cannot provide direct information and details relating to a trauma or its sequelae, one would question the level of cognitive processing that had occurred.

Rather than an absence of repertoires, where a current threat is thought or imagined to occur, possible associated repertoires to be considered are the Disturbed and Defence Mechanisms ones. The Disturbed repertoire, with disrupted speech, indicating disturbed thought processing impacting on the mind-body as well as defence mechanisms indicate how the body is reacting to the perceived threat. The reactions are somatic and contain a strong emotional element.

In the moment strategies which are employed to overcome the reaction to traumatic memories and reminders could be indicated in the speech of veterans through gallows humour, protecting the person from uncomfortable thoughts or memories of potential death. In addition, the veteran might try to downgrade their experiences to minimise the effects it might have on them. Bringing to mind dependability helps to position the event within previously held beliefs about their occupation. Using a defective repertoire acts as a protective factor from the distressing memories and may either help the person to reconcile their actions or may produce a guilt or shame reaction that they were in some way defective. Denial also has a role as a strategy for dealing with trauma memories by not allowing the event to be considered in a personal way whilst using pronouns other than a personal one will help the client to distance themselves from the trauma memory.

Overall, the defence superstructure offers a theme for the reaction to a trauma, whereby the person strives to defend themselves against a repeat of the trauma. Psychologically and physiologically the self will try to protect the body from harm, with traumatic memories held in order to recognise future potential traumas.

4.2.5 Neuropsychology of Trauma and Associated Memory

In a DVD produced for veterans by the Australian Department of Veterans Affairs (Fothergill, 2009), an explanation of the way drills and training sessions, experienced by those who join the military, conditions responses in the brain leading to a significant difference in the way parts of the brain of a military personnel operates under stress compared to the brain of a civilian. In

particular, when faced with a stress-provoking situation, the serviceman's amygdala responds in a different way to a civilian's amygdala. This automatic response is produced by design so that the service personnel can carry out their job under high pressure. An example of this would be a situation where a civilian would run away from the sound of a car crash whereas the serviceman is trained to run towards the sound of a car crash. Furthermore, in response to stressful situations, the serviceman is trained to deal with situations with aggression.

When using the discourse function of positioning themselves as passive in response to stress, reacting to their training in an automatic fashion and not being conscious of resilience in the moment, this leaves the veterans taking on a passive, or unconscious, role in stress and resilience. This leads to the question of whether the person is reliant upon their training or whether they can take advantage of personal skills they might have. In the counselling room, the counselling psychologist must always ask herself, if the veteran is responding due to his training. As a civilian, we do not receive training in this way and must develop individual ways of responding to stressful situations and developing resilience. When a veteran is faced with coping with a stressful situation, is it this reliance on training, and therefore an automatic response, that leads them to use maladaptive strategies in a civilian setting – that is, using aggression inappropriately. Indeed, research is showing the increase in risky behaviour such as violence towards other people in the veteran population (eg Sherman et al. 2005)

A further scenario and position regarding automatic responses was commented upon by George:

“when any situation happens in war, the book goes out the window, it's chaos and erm, leadership is about making those underneath you do things that they really don't want to do in stressful situations, ie life-threatening situations” – George 9:7-9

In this scenario, George is pushing the troops to take on the automatic reaction to cope with the situation and in this, he is taking on a more conscious, proactive role.

Harrison et al. (2008) examine how servicemen's reactions to potentially traumatic incidences should be dealt with and conclude that the three main means of prevention from mental distress are preparation, group cohesion and support. This emphasis on preparation would seem to be born out in the role training has in reducing the effects of stress and improving resilience.

4.2.6 Dual Representation Theory

In the examples given for the dependable repertoire (3.2.4.5) above, we have seen veterans who have been able to reconcile the beliefs developed through training with their experiences, considering both the implications and consequences of their experiences, reflected in their use of terminology extolling dependence. However, if working with a veteran who has not been able to process traumatic events, where they are struggling to match their beliefs with their experience, the choice of terminology relating to dependence might reflect their anger, shame or guilt that they experienced at the time of the trauma. These emotional responses might be directed towards themselves, their colleagues, their superiors, the military organisation, an enemy force or higher organisations such as the UN.

Each of the examples of the dependence repertoire demonstrates the retrieval of autobiographical memories of both stressful events as well as times of resilience – a necessary element of VAMs in DRT.

In addition, and key for this repertoire, the interviewees' lexical terminology reflects the processing of information with regards to the past, for example, Joshua 7:5; in the present moments of the stress, for example – Jack 15:18-21; and after the event, for example, George 8:4-6.

On the other hand bodily interruptions to speech, as heard in the disrupted repertoire would seem to indicate autonomic and motor responses to stress experienced as they relate traumatic information and, therefore, SARs.

According to DRT, at times of trauma, lower level processing of information is carried out including a strong link between bodily sensation and events. We see in this d3D (physical) lexical repertoire, Oliver explains stress in terms of physical tiredness and resilience in terms of being physically fit and strong – relating both stress and resilience to his body rather than to his psychological ability in quotes 1:5-6; 5:8; and 2:1-2 he does open the window for resilience to be “mental” as well as physical. For stress, George describes stress in terms of exhaustion (George 13:10-11); this word can be applied to both physical as well as psychological. For Jack, his example of stress (Jack 1:14-16) is relating to a physical example – physical bullying – and how his response is also physical in standing up to the bully.

In using these metaphors, I gain the sense that the veteran is saying that he has to be physically strong in order to be resilient and that when they are exhausted, there is a physical recognition of going through a stressful period. Even when the veteran says they aren't experiencing stress, they respond with exhaustion.

Brewin (2001) points out that disorganisation of memory is an indicator for PTSD and that within the DRT, this would be represented by SAM's – disorganised memories, missing information, jumbled timescales. William 2:I seems to produce a relatively straightforward narrative of what he went through – providing a descriptive role in his discourse, which might otherwise be missing or compromised if William was suffering from PTSD. By contrast, William is coherent in his description of the situation which seems to demonstrate the memory is verbally accessible. This is demonstrable by William's referral to issues both in the past as well as in the present during this section (eg we had been sent out to look at a culvert – past; we have much more sophisticated systems now – present) (Brewin, 2001, p.375). Also, William demonstrates attending to information from the trauma situation from pre, actual and post the event (performance of army and IRA prior to incident; details during the event; emotional response following the event) which Brewin (2001, p375) says demonstrates further processed memories. In the emotional exclamation at the end, "My God! that was actually a moment of you know." William shows how he has explored the emotional response to both the consequences and implications of the traumatic event (Brewin, 2001, p.375).

4.3 Part 3

4.3.1 Ideas for Application of Analysis Repertoires to Counselling Psychology Sessions

In the introduction, I considered the simile of the process of counselling psychology being like a driver (client) having a co-navigator (psychologist) who sits beside them as they are driving along a route in their lives. The role of the co-navigator is to have some prior knowledge of how to get to B from A (as provided by text books with the 'hows' of treating PTSD) - in the metaphor a Sat Nav system. This research argues that the psychologist needs to include other information to aid the journey. The co-navigator will point out road signs and landmarks along the road journey, and takes into consideration other factors such as driving conditions, effects of the journey on the driver and driving styles. The psychologist will be using the processes going on within the counselling room to signpost things such as cognitions and behaviour to the client, as well as considering mind-body symptoms of stress. The psychologist, as co-navigator, has the advantage of taking a comprehensive view of the situations the client talks

about and might use the repertoires identified in various ways, as described below. The ideas are particularly focused on veterans if they have symptoms of PTSD, but can also be relevant if they have issues with symptoms of anxiety disorders, depression and other conditions such as substance dependence.

4.3.2 Professional/Objective Repertoires

4.3.2.1 Direct

William 2:17 provides a graphic picture of speech which is straight to the point and this reflects the directness of speech from veterans when being counselled. When the psychologist hears a veteran speaking directly, it can be useful to consider why they are speaking in that way, with you, at that time. Three possible reasons for this occurring in the counselling room can be considered: firstly, that directness might be a trait required of service personnel – responding to commander's questions with directness and a full and frank description of what went on.

The second possible reason for this direct language might be primarily a means to shock or disgust the counselling the psychologist and then to see how the psychologist reacts.

Finally, if the psychologist can cope with distressing information, the veteran might conclude that the person could be trusted to be told further difficult information which they would otherwise not reveal. Where a client holds guilt or shame about events they were involved in, it is important for them not to re-experience negative attitudes from those around them as to their involvement.

A way the psychologist might use this repertoire in the counselling room is to discuss with the veteran how other people might be expected to respond to these distressing events, such as seeing a colleague's brains over the pavement. This is not an everyday occurrence and therefore, exploring how the client responded to the event at the time and how they might think about it now can aid the repositioning of beliefs about the distressing events. To do this, one suggestion would be to point out how directly the veteran is describing the situation – an observation that civilians might not do. Consider why they are doing this – is it their training? Does it feel safer to consider it like this? Question the veteran if they are testing the psychologist? These questions around the process of the direct statements rather than about the content can open up the experience for the client and suggest to him that he is being 'heard' on a more complex level than just the content level.

4.3.2.2 Details (Debrief)

A more formal language style is used for Details (Debrief), perhaps reflecting the details that would have been required in information following a patrol or exercise. This type of detailed debrief would have been used to build a picture of issues going on and would have been key to maintaining security, and therefore the safety of the service personnel. Due to the seriousness and potential danger associated with the details of these exercises and patrols, it would have been imperative for service personnel to give very detailed information – a style which is not so occupationally necessary with civilians.

In the counselling room, the psychologist must question herself why it might still be important for the veteran to talk in great detail about operations they were on. One potential reason might be that the veteran is trying to sift through as much information as he remembers in order to check if he could have predicted an anxiety-provoking situation and therefore could have done something different. This reflects the amygdala's role in storing information from dangerous times in order for the person to recognise similar events in the future and therefore avoid the same type of dangers previously faced. This process, in itself can provoke a fight-flight response with the associated release of adrenalin in the body and the psychologist should note any anxiety-related physical symptoms and comment on them, in addition to potentially bringing the attention of the veteran to the amount of details he is talking of. This can highlight how this style of speech accompanies the veteran's need to process stressful information but that bringing up all the details can be a type of hypervigilance – repeating the fight-flight response.

If the details that are recalled result in accompanying stress or the details being recalled do not follow the same pattern each time they are told, this might indicate that the information is not processed yet, and the veteran may be trying to produce a semblance of order. As the process of memory storage is interrupted at times of stress, this can be used as an indicator by the psychologist to use a timeline to help the veteran order the events as well as use stress-reducing exercises such as breathing, visualisation and mindfulness to reduce the autonomic response.

4.3.3 Personal/Subjective Repertoires

4.3.3.1 Duplication

Emphasis of words in a sentence, indicated by duplication of words or phrases, may be providing additional security for the person in what they are saying, emphasising the construct

they are speaking about to themselves. Or it may be that they want the interviewer to listen particularly to what they are saying.

In the counselling room, a psychologist might be able to reflect this discourse process back to the client, saying perhaps 'I notice you said "great strengths" twice there' to see whether the client might produce a reason for the duplication. A more direct approach might be, 'When you use the words "great strengths", I wonder what would you like me to consider from that?'

There might also be a hint from the choice of words used by the veteran with regards to stressful events and one way a psychologist might reflect this back to the client is: 'When you use the words "great strengths" and say them twice, that makes me think about the great strength you would have had to have to get through that event'. This repeating back of the words the client used might help the client to see the reflection of the parallel processes of experiencing of the event with the choice of their language used surrounding that event.

4.3.3.2 Descriptive

At times the veterans would describe situations, not like the earlier 'Details' repertoire, which is plain and factual, rather than producing a rich narrative of their experiences. During these descriptive sections, the discourse seemed to indicate an attempt to portray a situation so that my understanding was greater. There was also an underlying effect – a sense of the veteran removing himself from the picture, therefore potentially reducing the potential for anxiety-provoking information being produced.

An alternative argument is that the descriptive repertoires allow the veteran to recreate the situation in a place of safety which then allows them to see how danger might have affected them. (Wessely, 2005; Greenberg and Wessely, 2009). Both these studies have found that recreations of events do not always follow concrete events but the veteran is constructing a narrative to suit a purpose.

In these circumstances, a psychologist might seek to capture some of the thoughts that are going through the veterans mind as they recall this information. Furthermore, the veteran can be asked probing questions to explore his memories of himself in the situation and how, thinking about later, makes him reflect on how he thinks about the event in the present.

Interestingly, from the example given in the results (William 2:15-3:11), as William proceeds with his narrative, there appears to be an escalation, not only of the description of what he

was going through, but somatically and tonally, the tone of his voice rises, probably indicating a rise in anxiety in his voice and he begins to make more hand gestures as he appears to “act” out his memory. It is as if there is a mind-body link which seems him physically trying to press an imaginary button which is emphatic – as his death would have been if the situation had not worked out as it had. If this physical acting occurs in the counselling room, the psychologist can bring the client’s attention to this action, to see if the client is aware of it in the first instance; and then to check in how the client is thinking and feeling in the moment of recalling the event. This helps the client to concentrate on in-the-moment experiences as well as recalling historic experiences. As the client becomes more aware of these experiences, these can be incorporated into the therapeutic journey.

4.3.3.3 Figures of Speech (including ‘Gallows Humour’ as a subject and the phrase ‘You Know’).

Burr (2003) makes the point that discourse serves the same role as a painting a picture and figures of speech help the ‘painter’ – the speaker – to use phrases to illustrate his point to the viewer of the painting – the listener. Figures of speech used by speakers will be derived from a variety of settings, acquired from an early age and tracking through the different areas the speaker has gone through. Although some figures of speech will have more universal understanding of their meaning, some will be more colloquial and in the counselling room, clarification of unknown figures of speech may provide the psychologist with useful information – to share the veteran’s meanings. Conversely, if a figure of speech is used in an excluding way, it can be helpful to explore why the figure of speech is being used in this way at the time it is used.

With regards to the expression ‘gallows humour’ it can be useful to acknowledge its importance as a subject for veterans and the role it plays in reducing stress and encouraging group cohesion.

With regards to the phrase ‘you know’ there are many ways that a psychologist can use it in therapy. Here we will examine three possible ways a psychologist might respond upon hearing its usage in a veteran’s discourse. One possible way is that, when the speaker wishes those who are listening to gain understanding from what they are saying eg “I want you to know”, the psychologist can acknowledge this by reflecting back ‘you want me to know this’. This shows the psychologist is listening and understands the importance of the information to the veteran.

Alternatively, it might be that the veteran is requiring the listener to acknowledge the thing they are speaking about – so the phrase “you know” is spoken in a questioning manner. If the psychologist does not know what the veteran is discussing, they can feedback, ‘I don’t know – please would you tell me about it’.

The third usage being considered here, is that the veteran may be seeking reassurance of what they think they know and checking the psychologist also knows this. When used for affirmation, the psychologist might choose to respond by acknowledging they have heard what the client has said and discussing the questioning of its meaning with the veteran.

4.3.4 Exclusive Repertoires

4.3.4.1 Derogatory

In the example of William, his words could be heard as trying to put across some information to me. However, the choice of words “suggest really strongly” carried an implication for me beyond trying to provide me with information. My felt sense on hearing this section of the interview is that William is suggesting that I am ignorant of military culture. The implication is I should have known about the topic we were discussing; without knowing this information, I cannot be considered seriously by him and others.

Of all the interviews, the one I held with William reminded me of working with a client who is working out whether he can trust me in a counselling relationship. There is a combative element within the discourse, a sparring. A supervisor from one of my placements during training once described counselling sessions as either like being a waltz – flowing and with easy movement between client and psychologist – or like a boxing match.

When working with a veteran, the psychologist can consider various aspects of this in terms of therapy. The psychologist could comment upon her felt-sense – that the tone and choice of words are impacting her by producing this feeling in her. Once this is brought out into the open, if the veteran acknowledges a derogatory motive, this can be discussed in terms of the therapeutic alliance and why the veteran is led to do this. [is there also an indication that William has not processed his experiences very fully and he needs to do more work in order to relate to people better in civilian life?]

Alternatively, the language that is “heard” as derogatory, with implied insults, use of swear words, hints at sexist language might often be presented as “banter” -language that would be

deemed acceptable between the “lads” and is often used to see who can be relied upon and who can’t. The psychologist might mirror this type of language and speech style in order to reflect back to the client an understanding of their speech style and reduce any perceived gaps in language. Acknowledging the use of the banter as a test can also be useful and help the client to voice concerns he might have that the psychologist might not relied upon. Acknowledging this difficult area can help the client to realise that the psychologist is realistic and aware of issues which might arise.

4.3.4.2 Difference

The issue of differences between the client and the psychologist is a common theme in the counselling room. It is known that difference can lead to schisms in the therapeutic alliance if not handled sensitively by the counsellor (eg Mearns and Cooper, 2005). Here are three ideas for addressing the difference repertoire: firstly, highlighting the terminology used by the veteran can help them to ‘hear’ their own language. For instance, ‘I wonder if you have noticed you have referred to” us and them” a few times now when thinking about the forces and civilians’. As the veteran ‘hears’ the terms they use, they will hopefully become more aware each time they use the terminology.

Following on from this, secondly, I would suggest exploring the meaning of these terms for the veteran – their importance and ways they use them. A simple question asking the client what he thinks about when he uses certain difference terms can capture in-the-moment thoughts and therefore feelings about potential difference that might be tied in with beliefs they hold from when they were serving. Once these have been examined, challenges might be possible as well as pointing out the difference in timing – once they were serving, now they are civilians.

Finally, I would suggest that the psychologist works on reducing the gap which might lie between the two of them in the counselling room by providing psycho-education to the client. This would seek to improve the clients understanding of the counselling process and that, despite differences in background, experiences and so on, the psychologist is able, willing and present to listen to the client (as would be suggested in counselling handbooks such as Corey, 2005).

4.3.4.3 Distrust

As I listen back to the interviews, I realise that there is the likelihood of a lack of trust on behalf of the interviewee towards me. I imagine the veterans might be asking themselves various questions such as: who is this person asking me these questions?; how will she use the

information?; will I be found out to be mentally unwell?; will she uncover some dark secret?; will I be found to be a “basket case”? As with all clients, trust takes time to develop in the therapeutic relationship. In order to meet this issue face to face, I would suggest that the psychologist comments on this process of becoming aware of distrust directly to the client.

I imagine a statement from the psychologist might follow these kinds of lines: ‘as I listen to you, I get the sense that you are uncertain of telling me things, that you might be worried what I might be thinking about you. Would that be accurate?’. This type of comment allows the client to know how the psychologist perceives their exchanges, gives the veteran permission to either agree or disagree with the statements as well as explore the meaning and necessity for trust in the counselling room.

4.3.4.4 Directive

The directive repertoire needs to be explored into why the veteran is positioning themselves in a directive position. This might be viewed as a positive repertoire, in that ‘equalises’ the power relationship between the veteran and the client. By this I mean that, often the client can feel the psychologist holds the power balance in the counselling room. When a client is being directive, the power balance can be reversed as they are speaking from a position of knowledge that they wish to share with the psychologist. [on the other hand and perhaps more likely it could be a defensive stance; to position the client as superior in status (officer) or experience (what could you possibly know?)]

One possible way to use this repertoire is by trying to improve the therapeutic alliance by acknowledging the client’s expertise in this area as well as being experts of their lives, compared to the psychologist. Genuine interest in topics can be commented upon as well as recognition of the expertise may help to improve the clients’ self-efficacy.

4.3.5 Mind-Body Connection Repertoires

4.3.5.1 3D Physicality

I am reminded that the work these veterans were carrying out in the forces was essentially physical and they would have had to work constantly on being fit for work. According to the PULHHEEMS procedure, described by Fear et al. (2010) in their research of the self-perceptions of servicemen who were medically downgraded, a serviceman’s ability to carry out work tasks is based mostly on physical capacity. The procedure is that those not deemed fit

would be downgraded until such a time that they could resume their duties or, in some cases, would lead to the serviceman being discharged from the forces.

This reliance on physical fitness may be helpful for the psychologist in considering why the veterans used the 3D metaphors for stress and resilience. Indeed, the Fear et al. (2010) study showed that even when the main reason for downgrading was “considered to have an important psychological component” (Fear et al, 2010, p. 252) the reason given for the downgrading was attributed to a physical condition – indicating the high importance placed on the physical and the downplaying of the psychological.

In the counselling room, as I listen to veterans describing stress and resilience in these “3D” ways, I am reminded of Babette Rothschild’s seminal work, “The Body Remembers” (Rothschild, 2000), particularly the chapter on using the body as a “resource” in counselling (Rothschild, 2000, pp.100-128). When a client is talking about experiences in physical terms, it is paramount not to dismiss these in favour of wanting to hear about cognitive or psychological reactions to stress. Listening carefully about why they would describe stressful times in physical terms instead of psychological terms will be important.

It is pertinent to remember that though psychologist might be used to talking about issues in psychological terms, it doesn’t follow that the client will be. This means, it’s important not to disregard any physical description used. If a person is talking in physical terms, then that is where the psychologist would work with the client, and in time there will hopefully be a progression from the physical to a place where the psychological aspects might become available to the veteran. Supporting the client to start noticing the relationship between physical and psychological side of events is an important aspect of working with veterans who have experienced a traumatic situation.

If we consider an evolutionary approach to the issues of stress and resilience, as Cantor (2005) suggests, our ancestors stored information about previous stressful situations, so they were, and we are now primed to be alert for potential danger in order to steer clear of it, the “psychobiological response patterns” (Cantor, 2005, p. 178). These primed physical reactions to stress will manifest themselves physically rather than psychologically. Taking this a step further, it might be possible that emotional stress is not picked up on by the veteran, but instead is converted into a physical injury or illness.

In order for this type of client to benefit from working with the 3D (physical) repertoire, I would suggest the use of physical metaphors that clients can relate to, use and build on in terms of encouraging their mind-body connection. This can then be done by the psychologist working with the client to consider how the body is reflecting what might be going on in the mind (van der Kolk, 2007) in order to tackle any traumatic experiences.

4.3.5.2 Defence Mechanisms

Throughout the interviews, I was aware of sections where the interviewees might be experiencing levels of stress or prospective stress, either as they recounted difficult experiences, or were considering potentially confrontational subject matter. During these times I noted that various discourse interruptions occurred which were often non-verbal - physical in nature - rather than using language.

As the interviewer sitting listening to these defence mechanisms, I wanted to gain an understanding of what might be communicated in these mechanisms which would add to my understanding of the veteran's discourse. For example, William exhibits two physical reactions after a long period of describing an anxiety-provoking situation – exhaling then yawning. These somatic reactions might be a physical reaction to the client talking about stressful situations and must consider them as part of the discourse. Maybe William is trying to relieve himself from a build up of physical stress from the words he has spoken? Or is it possible that he could be trying to distance himself from the potential "weakness" of stress. Maybe he is bored. Or maybe he doesn't want to talk about it as it is getting closer to distressing memories for him and he becomes defensive about talking about them further.

Alternatively, it may be that the exhale and yawn are caused by anxiety from recounting stressful situations triggering the body's autonomic fight or flight mechanism (van der Kolk, 2007), flooding the body with adrenalin and causing quick, shallow breathing, increasing oxygen take up due to the quicker breathing and a subsequent physical requirement to empty the lungs.

As the psychologist hears or recognises these defence mechanisms, where the client is defending themselves in the moment, the psychologist might consider using these processes to discover why the thought, or telling, of the stressful event is causing these defence mechanisms and even to see whether the client recognises they are defending themselves. By using commentary on the process of defence mechanisms within the counselling room, the client may become aware of the repertoire of defence mechanisms which they might typically use to

cope with stress and therefore, bring the experience of stress into the open so they can learn to cope with this in adaptive ways such as using breathing and grounding techniques to relieve the autonomic response.

Apart from exhaling and inhaling, other non-verbal defence mechanisms repertoires noted in the interviews included pausing before or after talking, laughing – especially after talking about non-humorous situations, clearing throats and needing to take a drink. In addition, a few of them appeared to use their body's to relieve stress, such as tapping the table. The verbal versions of the defence mechanism repertoire include using “gallows humour” such as Joshua ending his description of killing in Cyprus by using the word “funny” and William describing the “piss-taking” as “immense” when describing soldiers under extreme stress in Afghanistan. This is terminology that would be familiar in the forces, was remarked upon by most of the interviewees and can be used by the psychologist in the counselling room. One suggestion might be to note the use of the humour. Further exploration as to why it is being used in the present may then provide useful insight for the veteran, especially as a mechanism for reducing or avoiding stress.

Disturbed

When the interviewees were asked to reflect back on a difficult time during their service, for some the speech pattern audibly changed. This might be because, as the veteran thought back to the difficult times, their amygdala recognised anxiety-provoking memories and the fight/flight mechanism associated with the amygdala was provoked, releasing adrenalin into the body, reducing blood flow in the top half of the veteran's brain, and thereby reducing the efficiency of the speech centre in that part of the brain. As the language centre reduces in efficiency, the veteran's speech becomes less coordinated and the frontal lobe, involved in processing and organising speech is also compromised. This neuro-psychological process will be discussed in further detail in the next section.

In terms of how to use the disturbed repertoire in a counselling session, the psychologist must first be aware of the simultaneous cognitive and somatic processes and comment on their occurrences to the client. This could be in a simple enquiry such as ‘have you noticed you seem to be having some difficulties getting your words out?’. Or the psychologist might ask the veteran to identify his thoughts as he is considering the stressful event – to see if there is

any recognition of the stress he is currently experiencing. Some psycho-education about the body's autonomic response to stress would also be useful as well information on what somatic symptoms might be experienced. Following on from this, learning or recapping on stress-reducing activities should be employed to reduce the stress in the moment in order to demonstrate their ability to help alleviate the distressing symptoms.

4.3.5.3 By Design

From the examples given in the results section, Jack highlights the lack of conscious decision-making under periods of stress and puts this down to doing his "job". William describes a couple of situations as very frightening but then positions himself as being well trained and drilled. George talks about an "automatic resilience" which he indicates is due to training and Alfie takes this up by positioning his resilience within a mechanism that was in place. Joshua is more explicit by putting resilience down to training and getting on with the job.

These descriptions remind me of the process of operant conditioning, as famously described by Skinner in his 1938 book, *The behaviour of organisms; an experimental analysis* (Skinner, 1938). When people join the armed forces, they are put through a range of basic training, or drills, followed by more specific training which is specific to the role they will take on in the forces. Part of that training is to ensure that the serviceman will respond to potentially dangerous situations in automatic ways so that they can carry out their tasks in as safe a manner as possible. The training has associated positive and negative reinforcements (for example, receiving a crate of beer for achieving good results compared with getting out of the rain at the end of an exercise) as well as positive and negative punishments (for example, an increase in being shouted at by superiors compared with removal of weekend passes). The serviceman is trained through these reward and punishment systems until he can carry out an action in a prescribed way.

With this knowledge about training and the By Design repertoires, in a counselling setting, it would seem prudent to work out with the veteran whether the automatic responses they have learnt are helpful in their civilian life – probing the sub-conscious role that is taken up by the veteran and uncovering the conscious roles that are taken on by the veterans to cope with stress and resilience.

An example comes from George's interview whereby he talks of avoiding confrontation as his previous training and therefore his current potential response could cause problems:

“where there was a public scuffle, I would tend to walk away . . . also, would be frightened at my own strength, because I know I could look after myself without too much trouble”

One suggestion is for the psychologist, in conjunction with the veteran to work out whether the veteran is making decisions consciously or sub-consciously, based on his previous training which might still be operating in an automatic way. This might be done by examining his behaviour – or cessation of previously carried out behaviours and discuss them in the light of the operant conditioning. Behaviour experiments and targets might then be worked into a CBT plan for the veteran. These would act to reduce or even reverse the effects of the operant conditioning. Using George’s example above, we see a veteran who is scared of hurting another person significantly so he walks away from potential danger spots. This avoidance could also translate into home and social life where the veteran is scared of attacking those known to him and hence isolates himself as a form of protection.

4.3.5.4 Dependability

For some, in a life-threatening situation, the need for dependability was paramount and this is reflected in the discourse of the veterans. This dependability reflects the potential language used in training which reinforces the culture of dependability within the forces. By describing this repertoire as ‘dependence’ rather than say trust, teamwork or comradeship, I wanted to reflect the nature of the work that these people were doing, where dependence was more than just getting a task done. In a conflict zone, such as Afghanistan, the service personnel are, to a high level, dependent on their colleagues to help keep them from being killed.

However, as explained in a DVD produced for Australian veterans called “You’re not in the forces now” (Fothergill, 2009), when a colleague is injured or dies, or a service personnel is injured, the belief that dependence would prevent this is shaken. After weeks, months and years of operant conditioned learning that they will be safe as long as they follow their training, they struggle to reconcile their previous learnt understanding with the new situation.

In terms of process in the counselling room, one possibility the counselling psychologist might want to explore is the concept of dependence the client holds through the language the veteran uses. By listening to the way the veteran describes dependence on their colleagues, there may be a contrast between using words such as ‘surrounds’, ‘envelops’, ‘protects’ and ‘relying’ and other words suggesting independence: alone, detached, by oneself. Instead of

identifying himself with his colleagues, he might be isolating himself and cutting himself off from old colleagues.

By exploring the choice of words used when considering their colleagues at the time of the trauma, the counselling psychologist can help to highlight possible beliefs or difficulties in beliefs that the veteran might be experiencing, such as those described by Fothergill (above). By working through this and highlighting the difficulties of the previously held belief, the veteran might be able to start the process of reconciling events.

4.3.6 Refutation Repertoires

4.3.6.1 Denial

In the counselling room, issues that need to be considered by the psychologist include the changes in lexical terms over time. When an older veteran comments that the word didn't exist in their time, the psychologist needs to acknowledge that this might be true – that lexical changes over time have meant the word is used for different reasons over different periods of time.

Another consideration is that the veteran does not recognise the psychological impact of stress; in this case, the psychologist might probe the body link first and encourage a connection with the mind after the veteran recognises the somatic symptoms of stress. Furthermore, the implications of denial of stress need to be discussed in terms of the culture of the forces. To admit a position of stress at the time of service might have opened up the service personnel to various career and personal difficulties, hence denying its existence protected them. Finally, consideration is needed that denial might be used to defend the person in the moment because to analyse one's feelings in the moment might lead to a compromise of the job they are doing.

4.3.6.2 Defensive

It is not unusual for clients to be defensive in the counselling room so to pick up on defensive styles in the veterans' discourses is not unexpected. The defensiveness in itself suggests a few different roles are being played out within the discourse between the co-respondents and myself.

Using William (William 17:16-22, 18:1-16) as an example, the sense that I took from this section of the interview was that he was being defensive – but as the psychologist I

have to consider whether my receipt of his discourse could be misplaced and maybe there was genuine confusion over what I asking him. If this was the case, I would suggest finding out what is going on for the veteran by direct questioning.

Alternatively I wonder if there may be other reasons for this discourse: William not wanting to think about stress or possibly being obstructive. His statement did not sound like a question looking for clarification hence my heard understanding that he was using it to be defensive. In these possible scenarios, Egan (2007) would describe this listening to the discourse as “the thoughtful search for meaning” (Egan, 2007, p. 89). The psychologist must consider what might be going on for a veteran such as William in the discourse, searching for his meaning of the discourse and then checking with him, but with the awareness that the defensive stance was the intended purpose.

William’s discourses in 3 and 4 are delivered in a tone of voice that suggested to me defensiveness. Again, my taking the tone as defensive maybe a mistake if this veteran genuinely believes that pragmatism is better than fretting over a situation he can’t change. Added to this, there is a finality in the subject matter he has chosen which implies to me that I mustn’t go there because the situation has been finished – “what’s happened, happened, you’re not going to change it” “if a bullet kills you, it kills you and that’s that”. This doubling up of message is powerful in the moment and I imagined myself as a psychologist in the counselling room, faced with such a “wall” of defensiveness. In order for the client to experience being understood, it would be necessary for me to acknowledge his right to tell me things or not.

When the veteran is challenged about comparison of dangers in different theatres before William 4, the tone of voice is again defensive against the interviewer – but in this scenario there is a sense that the defensive tone may also be a defence mechanism. I have tried removing a previously held security blanket of revealing the idea of downgrading, and the veteran becomes defensive as the reality of death is apparent in his own service as well as with others.

I also speculate if this type of defensive language has an underlying subtext – “who do you think you are” and I wonder if the interviewee waits to see if the interviewer can take up the challenge - “why would you want to do that?” This is William’s response to being asked if he had reflected on a tough situation afterwards. In a sense, there could be a no-nonsense reason why a service person wouldn’t reflect on a tough situation. But William uses the second person pronoun in his answer – “you” – in doing so maybe he doesn’t want to consider that

“he” did it as this might reflect him trying to ascribe a negative action (in his view) to the interviewer instead of the interviewee. This becomes a possible scenario when William considers this type of reflection to be “blinking off” – “feeling sorry for yourself”.

In William’s final example, 5, the choice of words “latched onto” accompanied by a defensive tone of voice leaves me in little doubt that he is defensive about me reflecting words back to him.

In the above examples, I have “heard” discourse as negative towards or against me as the interviewer. Not only must I mull over the situation of the interview, but I am left questioning my knowledge, or wondering if they are testing me to see what my reaction might be. In a counselling room, clients may challenge the therapist to see what reaction is provoked. Ultimately, a client needs to be ‘held’ by the therapist, even though they may not realise or explicitly consider that to be important. This ‘holding’ is otherwise known as containment, coming from the psychodynamic tradition and is an important element of the counselling (Gravell, 2010).

In response to William’s challenges in 1 and 2, I took some time to explain some of the disturbances attributed to stress which are experienced at a later point in time – nightmares, flashbacks and intrusive thoughts (eg van der Kolk, McFarlane and Weisaeth, 2007). By doing so, I was hoping that the sharing of psychoeducation might reduce William’s defensiveness and ameliorate the interview. One perception might be that, as in the counselling room, the psychologist holds a level of power by having knowledge of psychological responses to stress which the client might not be explicitly aware of, although they may have experience of them. By explaining the processes in greater depth, any power differentials held might be reduced so that both parties meet at a similar place, reducing the need of one for defensive reactions.

4.3.6.3 Downgrading

Down-playing – graded experiences of stress – try to slot themselves in to gauge how they are feeling. As long as they haven’t experienced what the others have experienced, they are okay and can work on coping with their stress levels. I wonder what it would be like to work on a list of stressful outcomes and see how people rate them – according to their own experiences. Like a safety mechanism – by comparing your experiences to others, it keeps you safe – grounded and you know you can cope. Downgrading your own experiences – well, I know my experiences weren’t as bad, I don’t have anything to complain about – I’m fine because I didn’t

go through what these poor buggers are having to go through now. The other's experiences are worse than mine so I will be okay.

With downgrading, is the movement of discourse to minimise their own experience and therefore cause them less distress? Or is it to imply they didn't feel stressed to me – I might think they were less of a person if they rated their stress really high? Is there a question of comparison with others – positioning their own stress – trying to gauge and make sense of their experiences in order to reassure themselves and bring their own stress reactions down in retelling and framing their stories in relation to other's experiences.

There is evidence that would back up the interviewers in asserting that others who are involved in a greater number of contacts during their service, that is increased numbers of exchanges of fire, involvement in bomb incidents, including the grisly and oft-cited reason for PTSD – collecting human remains and clearing up after a bomb (Ursano, Benedek and Engel, 2007).

4.3.6.4 Personal Pronoun

Throughout the interviews, I asked the interviewees to describe situations that were personal to them. I was struck time and again by the number of times the response came back not in the first person pronouns, but using other pronouns – “we”, “you”. In the counselling room, it would be important to draw the veterans' attention to the pronouns use and encourage them to stick as closely to the first person pronoun when recalling a personal experience. When a veteran is reluctant to do so, or seems unable to stick to this, the psychologist can ask probing questions as to what is going for them in the moment, in order to clarify underlying reasons why the veteran cannot place themselves within the event.

4.3.6.5 Defective

In the counselling room, when the psychologist hears the client using negative adjectives, I would consider drawing the attention of the client to their use of language in the moment. By using this in-process type of intervention, the client may become more aware of how their language might have been influenced by the culture of the institution that they worked within and they can check out for themselves, how that language translates into their views of mental health issues. A possible challenge for the client might be to ask them to provide a more compassionate version of their language to compare the two different positions. This would open up a spectrum of choice of language with which to describe stress, rather what appears

to be a polarity of language: positive language for mental well-being and negative language for mental health issues.

4.4 Part 4

4.4.1 Linking the Analysis to Other's Research

There is much doctoral research, often using phenomenological approaches, to explore the experience of veterans, so it is hoped that this exploration of the language used by veterans may be used by practitioners in conjunction with the other research to enrich their knowledge of this user group. In addition, I am curious about potential links between language use and production and neurological issues. As more studies are developed showing brain processing particularly under stress, there could be interesting links between the repertoires identified and neurological processing of stress.

When considering the conclusions of this research – a number of repertoires have been identified and a superstructure is proposed under which these repertoires can be examined – it is important to consider how these findings might be assessed compared to other's research. An example of this would be Inbar et al. 1989, considering stress under difficult conditions. The downgrading of personal stress compared to others in active battle situations was heard in many accounts, and this might indicate an underlying acceptance of stress in certain circumstances, such as physical fighting. On the opposite side of the scale, the defective repertoire might be used more when it is considered someone hasn't got a 'valid' reason to be stressed, and therefore the leader's attitudes are less inclined to these people.

Another example of linking the results of this research to other's work is in the mind-body repertoire which highlighted the close connection between the psychological processes occurring and linked them to bodily sensations. When considering the work by Rothschild (2000) and van der Kolk, McFarlane and Weisaeth (2007) which are both specifically in this area, it was fascinating to hear the veteran's use of body physical descriptors when asked to describe stressful situations. It appeared that there was no division and thoughts were intimately linked to bodily memories of the situations. Both pieces of work talk of the need to use body sensations as part of the counselling process and this is borne out by the repertoire being found in veteran's interviews.

Where some research has been carried out into the culture of the military, and increasing attention to gender issues, the repertoires may become an interesting way of considering how

culture is passed from one to another in the forces, and how this can sometimes be beneficial, but may also present difficulties. In particular, when someone leaves the forces and the social constructions for stress and resilience are considered differently by the people around the veteran, this can produce difficulties in trying to reconcile the two, sometimes opposing, constructions of the phenomena.

In particular, it will be interesting to see how the repertoires might be contributing to issues associated with PTSD, such as avoiding subject matter, places and people connected to traumatic situations. In particular, the down-grading repertoire may be an indicator that someone is trying to avoid considering the personal impact of the trauma or cannot process the information, so down-grades it in order to reduce feelings of stress.

Finally, as discussed in sections 4.2.3, 4.2.4 and 4.2.5, various repertoires have been examined in relation to theories of PTSD and processing of memories as well as starting to consider the neuropsychological effects of stress and resilience in the way veterans speak about their experiences.

4.4.2 Issues with the Current Research

I wrote earlier of my unease with my choice of words “stress” and “resilience” at times in the research process. I felt that these words had limited the research at times, especially when I was considering the symptoms and treatment of PTSD in the counselling room. Whereas the participants were talking about stress, the fact they were not asked specifically about trauma, means that the repertoires in the analysis section may not be ‘valid’ for working with veterans who have experienced trauma. As I revisited some epidemiological studies such as Gould et al. (2008), I was reminded that the percentages of veterans accessing mental health services suffer from issues such as depression, anxiety and substance abuse are greater than those with symptoms of PTSD, and therefore, my midway concerns were slightly eased.

Another issue, which I was concerned about from an early stage after my recruitment and interview stage, was the number of commissioned officers versus non-commissioned personnel who participated. Again, looking at epidemiological research, such as Iversen et al. (2008) factors such as higher educational achievements and rank tended to be protective against mental health issues. It would therefore, be useful to repeat the research where the majority of participants were mostly non-commissioned veterans, to see if similar repertoires appeared or if major differences occurred. This would require a different recruitment procedure,

utilising specialist NHS trauma services and various relevant charities and organisations such as the Royal British Legion to access a wider possible participant pool. Also, from a geographical point of view, all of the interviews took place in England, so may reflect a location bias as well. Any future research would have to take this into account.

In defence of the quota of commissioned versus non-commissioned officers it has been noted that commissioned officers are less likely to access services such as those offered by Combat Stress (Busuttil, 2008), in favour of private counselling and accessing NHS services. This may mean there is a 'hidden' group of veterans who are not accessing specialist services but may still be trying to cope with the after-effects of combat-related trauma. In interviewing commissioned personnel, as well as or instead of the non-commissioned ones, this study might highlight this issue and hopefully there may be some reduction in stigma that they too suffer from stress and need to access counselling to help process troubling memories.

4.4.3 Building on the Research

As the research progressed, there has been time to consider how this piece of work might lead to further studies which would be of interest in developing this theme of considering the veterans' language as a key to unlocking their cognitions. One possibility would be to conduct a series of interviews with the same participants, rather than one-off interviews. After interviewing one of the participants twice in this research, I realised that the formalised way he had spoken in the first was absent in the second. This reflects the experience of the counselling room with clients who, as they become more familiar with the psychologist, will relate to the person in a less distant fashion as the relationship develops. One immediate issue would be that the person, having experienced the first interview and knowing the research was interested in their language, would probably affect how they spoke. Not to reveal this aspect of the research until after all the interviews had been conducted would raise ethical concerns in attempting to be as congruent and transparent as possible and would need further consideration.

With regards to the analysis conducted, and the emergence of the defence superstructure, there would be an argument for utilising a Foucauldian discourse analysis research approach. Where Foucault argued that language is concerned with power, and with the armed forces being inextricably concerned with power, it would seem appropriate to consider how the power relationship with the armed forces influences and is demonstrable in the language that someone connected to that institution.

4.4.4 Self-Reflections on the Research

4.4.4.1 Hesitancy

I noted during Joshua's interview, from my own discourse style, I was hesitant in my questioning style. The effect on me was to consider whether I was not feeling confident sitting in the room with the veteran. This lack of confidence may have been due to: uncertainty about the questions I was asking; uncertainty about the reactions of the veteran; experiencing a felt-sense of the difference between us as civilian and veteran (of me not having experienced what he had been through and therefore, uncertainty of what would be spoken of. On listening back to the recording, I wonder what differences there might have been if I had been more robust. Further, I speculated if this hesitancy was present in a counselling situation, how the veteran would react – would they perceive the hesitancy as fear – and, therefore, be less likely to open up to them. In terms of improving my professional delivery of counselling psychology, I need to consider that a veteran, as do other clients, need and want someone capable of listening to their often difficult experiences with professionalism.

4.4.4.2 Process Mirroring the Research

Before coming up with my research proposal, I wanted to steer clear of issues that have affected my life as I felt this would be too personal to research. I chose to research an area of life that I find fascinating as well as important. Throughout the research, however, I have found that it was I who was struggling to defend myself and the work I had been doing. My defences held me locked into a state where I could not write up the research: it was as though I had lost my voice. As I reflect on this, I wonder how much this mirrors the veterans' experience of being so uncertain about themselves and their felt-experiences, that they lose their voices in their efforts to defend themselves. As I have struggled with my own voice, I struggled to give them their voice. This has materialised itself in being uncertain of how to write up the thesis; to increase my stress and bring down my resilience; has altered my own discourse repertoires and has left me considering how I process information under stress!

The experience of conducting this research has taught me to examine how much I defend myself, both outwardly and internally. I have realised that developing my voice and my discourse is important. When I read other's thesis using discourse analysis, I found myself petrified that my analysis was nothing compared to theirs. Breaking through this, I want to assert that my interpretations have as much validity, and therefore, so does my voice. I realise I am not a natural solo researcher and through this undertaking, I have had to discover new,

and hopefully healthy, ways of dealing with my stress. In doing this, I hope I have gleaned more sympathy for those dealing with stress on a regular basis which will be invaluable in practice.

4.4.4.3 Self as Counselling Psychologist in Training

As I come towards the end of my formal training to become a counselling psychologist, I realise that I take on this mantle more often. I noticed with the first three interviews that I found it hard to separate techniques I would use in my practice as a counselling psychologist from the interview process. I was also aware of being concerned about pushing the participants to reveal more information than they felt comfortable with. There was also a moment in the third interview, when the participant revealed a traumatic moment from an overseas tour of duty in which a colleague died, when I found it very difficult to remain in the role of interviewer. My inclination was to step into counselling psychologist mode and, although I used some techniques to check containment of emotion before the participant and I parted, as well as reiterating sources of help he might find useful, I found myself having to draw back from what felt like a natural position.

4.4.4.4 Self as Interviewer

In the first interview, I found it hard to come to a place of interviewing the participant, I believe, partially because I knew the participant, but mostly, I believe, due to a general lack of experience of interviewing people prior to this research. I was aware for all interviews that I wanted to present myself as professional in the process, but found the process of asking the questions, listening to the person's answers, working out when to prompt for further information and then decide which question to ask next, exhausting. As I became more used to the questions, I found myself settling into the process quicker and more easily but still found it alien! In the last handful of interviews, I found myself slipping into a conversational style of talking, taking the interview away from the semi-formalised structure of asking questions to responding to what was being said by the interviewees.

4.4.4.5 Self as Woman

Since all my participants were male, I explicitly asked them if they had held back from saying anything due to me being a female, not really expecting them to acknowledge this in the moment, but to highlight this difference and to check in if they were aware of it. Traditionally, those serving at the front line would only have been male and the female place within all services has only recently been developed. Hence, the way that stress is talked about in front of a woman may still be different due to cultural reasons. I was aware of trying to imitate

some of their language, to match their style of discourse during the interviews and to use military technical language, in order to try to lessen any potential gap.

In the back of my mind, I was also aware of a conversation I had had with a woman working in a veterans' counselling situation. We had discussed a potential "Florence Nightingale" effect of why women might want to become involved in counselling veterans, which we both acknowledged had an element of truth for us both. With this in mind, I was aware that my interaction with the participants in some way reflected the possible relationship I might have with veterans in a counselling setting. This presented its own challenges in ensuring ethical boundaries during the interviews were maintained as well as considering how, since all qualitative work is biased in the sense that it is the subjective work of the researcher, how could I reduce any potential bias which might impinge on any work being done.

In my self-reflections, I have concentrated on my own gender in relation with the participants at the time of the interviews and how my gender affects my interpretation of the interviews. But I have also considered how the participants' gender affected their participation, their culture of masculinity from before, during and after being in the forces. I am left wondering how they see themselves as men in each of these phases and how this may subsequently be reflected in their discourse and cannot be separated. It is not possible to comment on causality, but in the research I can comment on occurrence – of positioning and lexical choices which appear to me to reflect the masculinity of the participants. In particular, from discussions regarding the findings, the concepts of defence - heroism – kill or be killed – not allowing for emotional expression – or only proscribed formats – black humour versus crying. I reflect that these would not be considered regular conversations for a woman to have – that the masculinity is so apparent and opposite to me as the female listener.

On the opposite side to the language of bravado, strength and defence, is hearing the man being able to explore the feminine with me. When someone says, I've never spoken about this before, I have often been left wondering if it is exactly because of the difference in gender which has led to the opening up of subjects which could not be explored. As a female, working in the counselling room with a male, this is an important area to explore both personally and within the counselling session.

4.4.4.6 Self as Civilian

En route to the proposal stage, I was fortunate to spend some time at a stress conference overseas and then some months later, to discuss research ideas with some current UK armed forces members. In both instances I considered that, as a civilian with no military track record, I was kept at arm's length. Because there can sometimes be a lack of understanding between military and civilian worlds, I view this distance as a defence against negative impact. Interestingly, at the time, there had been widespread media coverage of a private conversation that His Royal Highness, Prince Harry, who had been serving in Afghanistan, had had with colleagues. The use of language that was considered acceptable in one location was held up as an example of unacceptable language use in another situation – an important element in discourse analysis. I was aware, therefore, that I was asking my participants to put their trust in me with their words they had spoken. I was also aware of wanting to reassure them that I meant no negative harm to the military – that that was not the purpose of my research.

I would also repeat my copying their language patterns as I wanted the distance between them as a veteran and me as a civilian to be minimised – one of the main aims of this research being to try to reduce the language gap of veterans and counselling psychologists when using psychological therapy services.

4.4.4.7 Self as Researcher

My view of myself as researcher developed over the process of writing the proposal and completing the process of research. Initially, the coat of researcher felt uncomfortable, not made for me, made out of a strange cloth that I fought against, not fitting or perhaps me fighting inside to be rid of what I felt was constricting. As the process has been passing, I have become more comfortable in the role of researcher – more prepared to own it rather than be a carrier of it, and sometimes even being happy to be wearing the coat!

4.4.4.8 Self as Conversationalist

In my sixth interview, I felt there was a further change in the self I see within this research. The participant and I began to have what I would describe as a conversation within the interview – more of a sharing of ideas, potential hypotheses and how the previous interviews were shaping the later interviews. As the discourse seemed to take on the mantle of a more natural conversation, I did not hold back from departing from the prepared questions, especially as the participant was answering them within his discourse. The unfolding of this dialogue and the interaction between the participant and me as interviewer was interesting as I

felt I became as much a participant in the process, rather than an interviewer who, in some way, holds some level of power within the interview process. This led me to consider whether I might re-interview my first participant, who was known to me. I had wondered, if considering the interview more in the light of a conversation, whether I might glean further insight from what was said as well as the 'how's' and 'whys'. In the end, the second interview did not have the flow I imagined it might have had and on discussion with the participant afterwards, this flow was not just noted by me! In fact, he responded that he had felt less inclined to talk in the second interview, possibly because he knew that I was concerning myself with discourse analysis and this knowledge affected the way he chose to speak about issues.

Concluding Expression of Hope

Interviewer: "I don't understand where the yellow pee comes in."

Veteran: "What are you talking about – yellow pee?"

Interviewer: "You said you were going to give me an example by discussing yellow pee."

Veteran: "L-O-P"

Interviewer: "Oh my goodness!"

(conversation with a veteran, July 2011)

This snippet of discourse occurred during a conversation I had with a veteran. The veteran was explaining why a physical explanation of stress and resilience was so important for people in the forces. I had been surprised when he said he was going to discuss "yellow pee" – not a conversation I would normally have with a veteran, so I tried to imagine how this might add further light to my findings. As I listened to an explanation about naval navigation procedures, I grew confused and thought, "he still hasn't mentioned this yellow pee thing – I wonder how it comes into the explanation". I voiced my confusion. The veteran corrected my misunderstanding! I subsequently learnt that 'LOP' is a three letter acronym for a shipping procedure.

Although I end my thesis with a humorous example of misunderstanding between myself and a UK veteran, my hope is that this research might, in some way, help to overcome misunderstandings between veterans and psychologists so that, humorous or not, misunderstandings do not stand in the way of therapeutic gain. Instead, by grasping an intimate understanding of language used by this group, it is my wish that the experiences of this client group are improved, both in the counselling room, as well as in their symptomology.

Section A References

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Section A Appendix A PTSD Criteria

309.81 DSM-IV Criteria for Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following have been present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- (2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- (2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
- (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). **Note:** In young children, trauma-specific re-enactment may occur.
- (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

- (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
- (3) inability to recall an important aspect of the trauma
- (4) markedly diminished interest or participation in significant activities
- (5) feeling of detachment or estrangement from others
- (6) restricted range of affect (e.g., unable to have loving feelings)
- (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

Section A Appendix B Proposed Criteria for PTSD, DSM Fifth Edition – Updated 20 August 2010

G 03 Posttraumatic Stress Disorder

A. The person was exposed to one or more of the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, in one or more of the following ways: **

1. Experiencing the event(s) him/herself
2. Witnessing, in person, the event(s) as they occurred to others
3. Learning that the event(s) occurred to a close relative or close friend; in such cases, the actual or threatened death must have been violent or accidental
4. Experiencing repeated or extreme exposure to aversive details of the event(s) (e.g., first responders collecting body parts; police officers repeatedly exposed to details of child abuse); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Intrusion symptoms that are associated with the traumatic event(s) (that began after the traumatic event(s)), as evidenced by 1 or more of the following:

1. Spontaneous or cued recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream is related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content. ***
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
5. Marked physiological reactions to reminders of the traumatic event(s)

C. Persistent avoidance of stimuli associated with the traumatic event(s) (that began after the traumatic event(s)), as evidenced by efforts to avoid 1 or more of the following:

1. Avoids internal reminders (thoughts, feelings, or physical sensations) that arouse recollections of the traumatic event(s)
2. Avoids external reminders (people, places, conversations, activities, objects, situations) that arouse recollections of the traumatic event(s).

D. Negative alterations in cognitions and mood that are associated with the traumatic event(s) (that began or worsened after the traumatic event(s)), as evidenced by 3 or more of the following: **Note:** In children, as evidenced by 2 or more of the following:****

1. Inability to remember an important aspect of the traumatic event(s) (typically dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent and exaggerated negative expectations about one's self, others, or the world (e.g., "I am bad," "no one can be trusted," "I've lost my soul forever," "my whole nervous system is permanently ruined," "the world is completely dangerous").

3. Persistent distorted blame of self or others about the cause or consequences of the traumatic event(s)
4. Pervasive negative emotional state -- for example: fear, horror, anger, guilt, or shame
5. Markedly diminished interest or participation in significant activities.
6. Feeling of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., unable to have loving feelings, psychic numbing)

E. Alterations in arousal and reactivity that are associated with the traumatic event(s) (that began or worsened after the traumatic event(s)), as evidenced by 3 or more of the following:

Note: In children, as evidenced by 2 or more of the following:*****

1. Irritable or aggressive behavior
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance -- for example, difficulty falling or staying asleep, or restless sleep.

F. Duration of the disturbance (symptoms in Criteria B, C, D and E) is more than one month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., medication or alcohol) or a general medical condition (e.g., traumatic brain injury, coma).

Specify if:

With Delayed Onset: if diagnostic threshold is not exceeded until 6 months or more after the event(s) (although onset of some symptoms may occur sooner than this).

*** *Developmental manifestations of PTSD are still being developed. The term 'developmental manifestation' in DSM-V refers to age-specific expressions of one or another criteria that is used to make a diagnosis across age groups.***

**** *For children, inclusion of loss of a parent or other attachment figure is being considered.***

***** *An alternative is to retain the DSM-IV criterion***

****** *The optimal number of required symptoms for both adults and children will be further examined with empirical data***

Section A Appendix C Recruitment Material and Information

Dear (Friends, Colleagues)

As many of you will know I am on the Practitioner's Doctorate in Counselling Psychology programme at City University, London. A major component of my Doctoral work is to carry out a research project which will be incorporated into a thesis.

In order to carry this out, I am looking to recruit participants who have served in the British military (Army, Navy and RAF - both commissioned and non-commissioned) to take part in one-to-one interviews. Participants would need to be willing to be interviewed by myself regarding stress and resilience when they were serving in the military.

If you are ex-military and would consider taking part, please let me know.

If you know of any friends, colleagues and acquaintances who are ex-military and would consider taking part, please let me know their contact details (phone, email or land address) and/or pass on this email to them and ask them to contact me direct.

All participation would be confidential. Full details of the research will be discussed with potential participants and informed consent would be sought before any interviewing would take place.

The interviews will typically last 60 minutes. The interview would take place at a location convenient to the participant.

If you would like to participate and/or have any questions, please contact me:

Lisa Vallance
Second Floor Flat, 30 Lupus Street, London, SW1V 3DZ
020 7630 7514
0771 266 7577
lcvallance@btinternet.com

Thank you for your kind assistance in helping me to recruit participants for my research.

Kind regards

Lisa Vallance

Section A Appendix D Briefing Document

About the Research

As an ex-member of the British military – Army, RAF or Navy – you are being asked to consider participating in a one-to-one interview with myself, Lisa Vallance, about stress and resilience when you were serving in the military. The interview will take place at a mutually convenient location and will typically last for 60 minutes. The interview will be recorded using a digital recording then stored on my computer in a password protected file. A transcription of the interview will be made and held electronically in a password protected file. In addition to the interview, I will ask you basic biographical details.

About Me

I am a second year student on City University's Practitioner's Doctorate in Counselling Psychology. In considering various studies which show a greater number of ex-servicemen are requesting counselling services, there is little literature for the civilian counsellor to inform them of the particular occupational demands that are faced by ex-British military service personnel. In studying this area, I am aiming to build up a resource which will, hopefully, be of use in civilian counselling settings for ex-military personnel.

Subject Matter

Since we will be discussing issues regarding potential stressful times you may have found yourself in whilst serving in the military, I will verbally ask you prior to the interview if you feel that it is appropriate for you to take part in this study. If for any reason, you are concerned about any issues which may be raised during the interview, you may wish to reconsider your participation in the study. If this is so, or for any other reason, you have the right to withdraw and will not be asked any further questions by myself.

Confidentiality

Your identity will be protected and a pseudonym will be used in any printed material. In addition, any potentially identifying information will be changed to protect anonymity. Any personal details or information about you from your interview is dealt with strict confidentiality

at all times. I am bound by the code of ethics of the British Psychological Society, of which I am a member, and also the regulations laid down by City University when students undertake research.

Consent

If you are willing to participate in the research I will ask you to sign a consent form which I will hold in a locked, fire-proof cabinet. As soon as time regulations for keeping documents relating to the thesis have passed, I will destroy the consent form by shredding and will delete the electronic file of the interview.

Researcher Lisa Vallance

Second Floor Flat, 30 Lupus Street, London, SW1V 3DZ

020 7630 7514 / 0771 266 7577

lcvallance@btinternet.com

Supervisor Dr Jacqui Farrants, Deputy Head, Psychology Department

City University, Northampton Square, London, EC1V 0HB

020 7040 0172

Section A Appendix E Debriefing Document

Thank you for taking part in a one-to-one interview with myself.

As you know, this interview will be used in the research regarding stress and resilience experienced by ex-military personnel when serving in the military.

When accessing civilian counselling services, ex-military personnel have sometimes perceived a lack of understanding of the civilian counsellor to the particular occupational demands of having been in the military. This perceived lack of knowledge can become a barrier for the ex-military personnel continuing to seek help.

In studying the language of this group of people, I am aiming to build up an information guide to be used in civilian counselling settings for ex-military personnel. In order to produce this information guide I will be analysing the interviews, particularly look at the language that has been used when discussing stress and resilience. I will be looking for any similarities in the language used, which may be particular to those who have served in the military. By recognising the language used when talking about stress and resilience, the civilian counsellor may better understand the occupational experiences of ex-military personnel which may be helpful in breaking down any perceived barriers for ex-service personnel seeking help.

If you have any questions about this research, please don't hesitate to ask me to discuss any of the above. Also attached is a list of resources that you may wish to access if you find you have any queries about issues which may have been raised during the interview.

Please feel free to voice any issues either to me or to my supervisor:

Researcher Lisa Vallance

Second Floor Flat, 30 Lupus Street, London, SW1V 3DZ

020 7630 7514 / 0771 266 7577

Supervisor Dr Jacqui Farrants, Deputy Head, Psychology Department

City University, Northampton Square, London EC1V 0HB

020 7040 0172

Section A Appendix F Consent Form

- ☐ I have read and understood the briefing information provided regarding my participation.
- ☐ I have been given an opportunity to ask any questions regarding this information.
- ☐ I have been given contact details for the researcher and her supervisor.
- ☐ I have been asked by the researcher if there are any reasons why it may not be appropriate for me to take part in this interview and responded negatively.
- ☐ I understand that the interview will be recorded using a digital recorder.
- ☐ I understand that all personal data and the digital recording of the interview will be held securely, either in a locked cabinet or in password-protected files on the researcher's computer.
- ☐ I confirm that my participation in this research is voluntary.
- ☐ I have been made aware of what my participation involves.
- ☐ I am aware of any potential risks (if there are any).
- ☐ I have had questions concerning the study satisfactorily answered.
- ☐ I understand that I may withdraw my participation from this study at any point (before, during or after) without being questioned about my reasons for doing so.

Signed

Dated

Section A Appendix G Original Basic Set of Questions for use in Semi-Structured Interviews

- As you know this interview is about stress and resilience from when you were serving in the British military. Please would you give me an idea of what these words mean to you?
- How would you characterise times of stress and resilience from when you were serving?
- How did your training prepare you for times of stress and resilience?
- Are there strengths and weaknesses in the British service person? How would you describe them?
- What about times when people have not seemed tough?
- What kind of things would you do if you/your bosses/lads were having to cope with stress?
- A report in 2004 by the US army showed that 50% of service personnel would not report a stress-related issue because of fear that it would impact their careers and more than 50% wouldn't report stress-related issues due to possible issues with their colleagues. Do you think the figures would be similar for the British Army/Navy/RAF? Please would you suggest reasons why?
- The MOD has been trialling a programme called TRiM – trauma risk management – have you heard about it? (Interviewer will provide brief overview if not – senior officers trained to recognise stress reactions in personnel and approach person in pastoral capacity.) Did anything similar happen when you were serving? Would describe how “stress reactions” were dealt with when you were serving?
- Since leaving the forces, have you noticed differences in how civilians deal with stress and resilience? Please would you expand on any differences?
- Are there any questions you thought I might ask? Please tell me about them.

Possible probes (from Conrad, Blair, and Tracy, (2009):

- What was going through your mind as you tried to answer/as you were thinking about the question?
- You took a little while to answer that question. What were you thinking about during that time?
- It sounds like the question may be a little difficult for you to answer. If so, can you tell me why?
- What occurred to you that caused you to change your answer?
- You emphasized/ or you repeated [word]. Why was that?

- You seem a little unsure. Was there something unclear about the question?
- Clarify respondent's understanding of particular term or the process respondent uses.
- If I weren't available or able to answer, what would you decide it means?

Section A Appendix H Revised Basic Set of Questions for use in Semi-Structured Interviews

- As you know this interview is concerned with stress and resilience from when you were serving in the British military. Please would you give me an idea of what these words mean to you?
- Please will you give me examples of times of stress and resilience from when you were serving? How did you deal with them?
- Was there anything from your training that prepared you for times of stress and resilience?
- The MOD has been trialling a programme called TRiM – trauma risk management – have you heard about it? (Interviewer will provide brief overview if not – senior officers trained to recognise stress reactions in personnel and approach person in pastoral capacity.) Did anything similar happen when you were serving? Would describe how “stress reactions” were dealt with when you were serving?
- Please would you describe any strengths or weaknesses in the British service person with regards to stress and resilience?
- What kind of things would
 - you do if you were having to cope with stress?
 - your bosses do if they were having to cope with stress?
 - your boys/lads do if they were having to cope with stress?
- A report in 2004 by the US army showed that 50% of service personnel would not report a stress-related issue because of fear that it would impact their careers and more than 50% wouldn't report stress-related issues due to possible issues with their colleagues. Do you think the figures would be similar for the British Army/Navy/RAF? Please would you suggest reasons why?
- If there have been times when colleagues have not seemed tough, how have they been advised to cope with stress?
- Since leaving the forces, please would describe any differences you may have noticed in how civilians deal with stress and resilience? Please would you expand on any differences?
- I wonder if you held back from saying anything
 - Because I am a civilian
 - Because I am a woman
- Are there any questions you thought I might ask? Please tell me about them.

Additional possible questions:

What about stress due to relationships whilst serving – spouses or partners, relationships, family, friends?

If you were to talk to someone else about stresses, what kind of things would you say to your spouse/ partner, relationships, family, friends?

If you were stressed, what would you like people to have said to you?

Have you noticed any difference in the way you deal with stress and/or resilience now, as a civilian?

(if the participant has talked about a stressful period) What about after the moment?

There is research being carried out about potential additional pressure placed on service personnel due to the increased accuracy of weaponry. How do you think this would affect people's stress levels?

Section A Appendix I Possible probes (from Conrad, Blair, and Tracy, (2009):

- What was going through your mind as you tried to answer/as you were thinking about the question?
- You took a little while to answer that question. What were you thinking about during that time?
- It sounds like the question may be a little difficult for you to answer. If so, can you tell me why?
- What occurred to you that caused you to change your answer?
- You emphasized/ or you repeated [word]. Why was that?
- You seem a little unsure. Was there something unclear about the question?
- Clarify respondent's understanding of particular term or the process respondent uses.
- If I weren't available or able to answer, what would you decide it means?

Section A Appendix J

Biographical Questions

Which service did you serve in:

- ☐ Royal Navy
- ☐ Army
- ☐ Royal Air Force

Were you:

- ☐ Commissioned
- ☐ Non-commissioned

How long did you serve? _____ years

How many years has it been since you left the forces? _____ years

When you entered the army, what level of education had you reached:

- ☐ O-Levels, GCSE or equivalent
- ☐ A-Levels
- ☐ Degree, HND or equivalent
- ☐ Post Graduate qualifications
- ☐ Other

Section A Appendix K Additional Information

If after participating in this research, you wish to discuss any issues, please note the contact details for myself and for my supervisor:

Researcher's Contact Details Lisa Vallance
Second Floor Flat, 30 Lupus Street, London, SW1V 3DZ
020 7630 7514 / 0771 266 7577
lcvallance@btinternet.com

Supervisor's Contact Details Dr Jacqui Farrants, Deputy Head, Psychology Department
City University, Northampton Square, London, EC1V 0HB
020 7040 0172

You may also wish to contact your GP to discuss any concerns you may have from issues which may have arisen. Because the Government and the MOD recognise the particular demands placed on military service personnel, any ex-service personnel seeking counselling services via their GP are fast-tracked to reduce time spent on NHS waiting lists. If you decide to seek counselling services from your GP, please let him know that you are ex-military so that this fast-tracking can take place.

Other sources of information which you may find of use:

British Psychological Society St Andrews House, 48 Princess Road East, Leicester, LE1 7DR
+44 (0)116 254 9568
+44 (0)116 227 1314
enquiries@bps.org.uk
www.bps.org.uk

British Association of Counsellors and Psychotherapists BACP House, 15 St John's Business Park, Lutterworth, Leicestershire, LE17 4HB
01455 883300

bacp@bacp.co.uk

www.bacp.co.uk

Combat Stress Head Office, Tyrwhitt House, Oaklawn Road, Leatherhead, Surrey KT22

0BX

01372 841600

contactus@combatstress.org.uk

www.combatstress.org.uk

NHS Direct

0845 46 47

www.nhsdirect.nhs.uk

Veterans UK Service Personnel and Veterans Agency, Norcross, Thornton Cleveleys,
Lancashire, FY5 3WP

Freephone 0800 169 22 77 (UK only)

Orange, Virgin or 3 mobile, Customers will not be charged for the call by their provider

0800 169 34 58 Textphone facility (UK only)

+44 1253 866043 (Overseas)

veterans.help@spva.gsi.gov.uk

www.veterans-uk.info/

Section A Appendix L Analysis Cues

Constructions – terminology, style, grammar, metaphors (objects and subjects), other figures of speech (FOS)

Non-linguistics - sighs, breathing, tapping

Functions (F)

Context – interview – male/female, consequences for participants – helping, contribution to knowledge

Variability

Consequences

Why am I reading this passage in this way?

What features of the text produce this reading?

“Interpretive repertoires”

Positioning

“repairs”

Intonation

Delay

Lexical choices

Action orientation

Situation

Construction – discourse – constructed and constructive

hesitations and pauses; laughter; interruptions; doubt or certainty markers; specific lexical terms; forms of address; more about pronoun use; “local” semantic structures; turn-taking strategies; politeness; shifts in discourse; roles; positions; syntax; macrosemantics; coherence of discourse; style; rhetoric; positioning; power enactment in discourse production; mental stages of interviewee influencing presentation of views in their speech.

(Cues derived from: Willig, 2001; Willig, 2003; Potter, 2003.)

Section A Appendix M Coding List

Defence Mechanisms

(Delusional)

(Distortion)

Displacement

Dissociation

Distancing

Denial

Deflection

Disturbing

Doubting

Destructive

Detachment

Direct

Directed

Directive

Directional

Defended

Demands

Matter of fact

Difficulties

Details

Dependable

Sharing

Teamwork

Drink

Drugs

Bullshit – Dodge

3D – Physicality

Disciplined

Trained

Inactivity

First person/third person

Downgrading/playing
Brutal honesty - Directness
Duty
Driving Through
Down to Earth
Realism
Dependability - Responsibility to others
(By) Design - Automatic Reactions
Determined
Defensive
(Almost humour?)
Resolve – poss determination
Stoicism
Rationalise
Forward worry
Current okay
Past worry
Tense switching (in the moment, then memory)
Deliberation
Deliberate
Deadpan
Living up to traditions
Genetic
Environment
Other's expectations
Common purpose
Guilt about those left behind
Anger at treatment of spouses – not looked after in the way veterans looked after their men
Isolation
Forward thinking – seeing the wider picture
Duty (Service)
Dispassionate
Devotion to each other
Proactive in friendships
Guilt about another's death
Trying to cover all eventualities to avoid stressful situations
Constantly checking

Getting it out at last

Avoiding the difficult stuff

YOU KNOW

Hiding from emotions

Hiding from stress

Examples not “fantasy”

Rose tints re past cf to present

Isolation

The horse on the table

Section B Critical Literature Review

**In Defence of Our Forces:
A Critical Literature Review of Recent Predominantly UK
Mental Health Research Regarding Current Armed
Forces and Veterans.**

B1 Introduction

Issues facing current armed forces and veteran personnel, who are suffering from mental health issues including post-traumatic stress disorder (PTSD), have come into stark focus in recent years. Coinciding with the twenty fifth anniversary of the Falklands Conflict in 2007, a report by Michael Bilton highlighted the difficulties British current and veteran personnel faced in accessing suitable treatment when they are suffering from mental health issues and combat-related PTSD (CR-PTSD) (Bilton, 2007). Bilton wrote that, although some counselling services appeared to be available if sought whilst still serving in the armed forces, for the British veteran who developed late-onset PTSD after leaving the armed forces, there appeared to be a lack of Ministry of Defence (MOD) provision of counselling services (Bilton, 2007). This increased the demands on National Health Service (NHS) provision of counselling services and the requirement for cost-effective and timely services became apparent. However, due to the specialist nature of CR-PTSD, the most appropriate counselling was not readily available, and there were lengthy delays before counselling could start due to waiting lists (Bilton, 2007).

B2 Current Armed Forces Research up to 2007

Research from around this time included a paper by Hacker-Hughes, Cameron, Eldridge, Devon, Wessely and Greenberg (2005), responding to an American paper by Hoge, Castro, Messer, McGurk, Cotting, and Koffman (2004) who had examined the mental health of American military personnel and perceived barriers to gaining care and reported as many as 20% of respondents had PTSD following recent tours of Iraq and/or Afghanistan. Hacker-Hughes et al. (2005) indicated that it was not necessary for service personnel to be as affected by combat stress as Hoge et al.'s 2004 study indicated. The American study did not mention any pre-deployment briefing; however, Hacker-Hughes et al. (2005) indicated that it was standard procedure for all UK personnel to receive a pre-deployment mental health briefing. Participants of their study were sent various questionnaires prior to deployment, and again on their return, but the results showed no depreciation in the mental health of the service personnel after the tour of duty. There were differences in designs of the studies and it was also noted that the geographical areas that the British troops had been deployed to were very different in terms of engagement to that experienced by the American troops. Importantly, this UK study involved a random sample of all personnel sent to Iraq including regulars, reservists and combat support and service support staff (for example engineers, nurses and admin staff) who would have fewer directly life-

threatening experiences. This could be a reason why reported PTSD figures were not higher in the UK study.

The Hacker-Hughes et al. (2005) paper used a brief screening type on a sample size of n=254 whilst a paper by Hotopf et al., (2006), started in 2003 and including a greater diversity of health issues being studied, had much larger numbers of participants (n=4722 {deployed}, n=5550 {non-deployed}). The study included personnel who were not deployed to Iraq as well as support staff. The research was rigorously designed by Hotopf et al. (2006) so the results can be relied upon to be robust. The author of this paper particularly noted that, as well as displaying more symptoms of PTSD, those engaged in combat situations are also likely to be abusing or dependent on alcohol.

The next research paper for consideration is a study by Deahl, Srinivasan, Jones, Thomas, Neblett and Jolly (2000) which investigated how operational stress training and psychological debriefing (PD) may prevent service personnel from experiencing lasting and debilitating trauma from combat scenarios. The use of PD as a tool 'in theatre' (on active service in military operations) – i.e. within 48-72 hours of a potentially traumatizing experience whilst being deployed - was available to service personnel, however this study found no significant difference between those who were offered this type of therapy and those who were not in subsequently developing PTSD. The study was fairly small (n=106) and there was a low incidence of PTSD in the groups tested. However, they highlighted the issue of high levels of alcohol and substance dependence and abuse which could be masking the assessment of psychological conditions such as PTSD. Another study by Jones, Rona, Hooper and Wessely (2006) highlighted the incidence of high alcohol consumption as well as increased psychological symptoms in service personnel, even when they were not involved in a high-activity deployment.

A study by Rona et al., (2006), funded in part by the MOD, used a longitudinal study of British forces to test any connections between existing mental disorders and subsequent disorders including PTSD. However, they found screening was not a useful predictor for the onset of later mental health issues. The MOD-funded study by Hacker-Hughes et al. (2005), mentioned earlier, did not agree with the findings which indicated the latest deployment of troops to Iraq would lead to similar issues that had been experienced after the conflict in Vietnam due to developing preventative measures and increased awareness. The findings may be due, in part, to issues such as differing types of operations but may also be due to methodological differences such as length of time to follow-up assessments and differing baseline prevalence measures.

In a further study by Rona et al. (2007), concern was raised by the first findings in a cohort study that showed, due to cuts in staffing numbers, personnel were serving longer terms in combat-related theatre which was resulting in higher numbers meeting criteria for PTSD as well as finding a “significant association” (Rona et al., 2007, p. 603) with severe alcohol problems. The implications for reducing the incidence of PTSD in current service personnel seemed to indicate personnel should have combat-related tours limited within fixed time periods.

B3 Veterans Research up to 2007

Research regarding veterans around the time of the Bilton article (2007) included papers on the failure of veterans to adapt to life outside the military leading to considerable numbers becoming homeless and a continuing unwillingness to report mental health issues including late-onset PTSD often co-morbid with substance abuse (typically alcohol and drugs) (Dandeker, Thomas, Dolan, Chapman and Ross, 2005). Rather than receiving treatment through the MOD, once they had left service they had to rely on NHS services. Whilst some felt capable of talking with non-service personnel, it was reported that others found reporting situations faced by armed forces personnel easier to discuss with people connected to the services (Bilton, 2007; Gale, Marquez, Al-Khudhairy, Saftis, Knottley and Azua, 2006; Gould, 2007).

B4 UK Military Mental Health Research in the Past Five Years

As we now commemorate the thirty year anniversary of the Falklands Conflict, in the last five years since the Bilton (2007) article was written, the situation has changed considerably with the Ministry of Defence, various government bodies such as the NHS, organisations and charities providing more counselling services. As well as this, there are many organisations and individuals producing research regarding the military and mental health issues in the UK. In the past five years alone the King’s Centre for Military Health Research (KCMHR) has published 169 articles on a variety of subjects in an assortment of publications. The topics which are studied and reported on are wide-ranging covering topics such as specific combat theatre reactions, historical issues, medical research and issues pertaining to veterans.

This critical literature review examines some of the papers produced by KCMHR in closer detail as well as a small selection of related overseas papers, predominantly American but also including an Australian piece of research. In considering the variety of subjects available, it was

necessary to discount research regarding historical aspects of military health, as well as papers regarding journalism, Gulf War Syndrome, medical complaints such as obesity and vaccinations, diversity in the forces and issues relating to terrorism for matters of expediency. Having removed these papers from the list available, of the remaining papers, various papers were selected for examination in greater detail. The papers will be examined for issues such as quantitative versus qualitative measures will be discussed as well as highlighting research for both current personnel and veterans including studies regarding different treatments. In addition, topics resulting from being involved both in theatre (in a combat situation) as well as on operations in non-combat areas will be reflected on.

Before looking at the first of these recent papers, it is important to take into account the funding sources for the research that is produced by KCMHR which is part of King's College London and grew from the Gulf War Illnesses Research Unit which was established in 1996. Although the organisation is not directly funded by the Ministry of Defence (MOD), the KCMHR is associated with the Academic Centre for Defence Mental Health (ACDMH) which is funded by the MOD. With regards to research matters, where research has been funded by the MOD, there is a declaration of this on the relevant paper. The declaration makes clear that the MOD is not involved in the data collected, how it is processed or analysed and is not involved in subsequent interpretations and findings. By drawing attention to this fact at the start of the review, the reader will be able to consider the information presented without having to negotiate whether any bias may have occurred due to sources of funding. Where authors have a potential conflict of interest, these are declared.

B5 Research Specifically Regarding Gender

As of April 2012, the KCMHR had posted on their website that a focus for further research would be regarding various issues affecting women in the forces. As women have only relatively recently been allowed to enter more of the armed forces, it is recognised that more research regarding the effects of service on them is necessary. In one of the most recent publications, Woodhead, Wessely, Jones, Fear and Hatch were concerned with examining potential gender differences in mental health issues when considering individuals' exposure to combat and various associated scenarios (Woodhead et al., 2012).

The research was quantitative in nature, involving two phases: firstly, they discovered there was a gender difference in how personnel viewed events they were exposed to. Men reported both greater risks to 'self' and 'others they were with' and there was also an associated negative view

of their deployment. By comparison, women reported fewer incidences of exposure to risk. Woodhead et al considered other factors in relation to this finding including the percentages of men and women undertaking roles such as front line combat positions (predominantly male) compared with medical assistance (predominantly female).

When the researchers used the self-reported exposure to trauma information and compared it with mental health outcomes such as GHQ-12 and the PTSD checklist – civilian version – PLC-C – there was no significant difference between the genders in terms of exposure compared with common mental health disorders and PTSD, although there was no direct relationship between alcohol abuse and exposure to trauma.

The second of the recent studies regarding gender being considered was by Rona, Fear, Hull and Wessely, published in 2007, which was concerned with evaluating women's health when serving in the forces. They note that as the number of women working in the military increased, from 1% in 1970 to 9% in 2005 (Rona et al. 2007, p.319) they were looking to see if there was a related rise in mental health issues. In particular, they were concerned with any potential negative mental health impact of working in combat zones over time and to see if any issues that occurred were at the same rate as men or if there were any significant differences.

Again, this was a quantitative study which looked at data regarding various mental health issues as well as alcohol consumption from two cross sectional studies of women who had served during the Gulf War of 1991, women who served in the Iraq war of 2003, men who served in the same Iraq war, another group who had served in Bosnia and a further group who were not posted overseas. Multiple logistic regression analyses were carried out and the main findings showed that whilst men showed more frequent alcohol misuse, women were scoring positively for general health issues and fatigue. In addition, there was a difference for women posted in the Gulf War compared to the Iraq War, although when the results were analysed according to age, rank and educational attainment, these were significant factors in protecting the older, commissioned women who had been in attendance in the Gulf War compared to younger, non-commissioned women who were posted during the Iraq war in greater numbers.

Apart from the two studies already discussed, there were no further publications from KCMHR from 2007 regarding gender issues which involved women working as military personnel, although many studies were conducted solely with male respondents. This gap in research has been noted by KCMHR in confirming this is an area for on-going research. The only other piece of research published by them in the last five years which discusses military issues in relation to women was by De Burgh, White, Fear and Iversen (2011) who carried out a literature review

on the effects of deployment of personnel on partners and wives, who were mostly female as the majority of those serving in the forces were male. In fact, none of the papers reviewed came from the UK, instead all being American in origin, indicating a definite need for UK research into this area as well, due to potential cultural differences and experiences.

B6 Research Regarding Unit Cohesion, Leadership and Morale

The next three papers which will be discussed are concerned with unit cohesion, leadership and morale. All three papers have been written in the past couple of years – Du Preez, Sundin, Wessely and Fear in 2012; Jones, Seddon, Fear and McAllister also in 2012; and Murphy and Sharp in 2011. Du Preez et al. were researching possible associations between unit cohesion and mental health issues using logistic regression analyses on various data collected from an all-male sample who had served in Iraq. Significant findings included that personnel who believed senior staff took an interest in their day-to-day experiences, developed lower rates of PTSD and common mental disorders, whilst those who felt as if they were well informed by senior staff experienced lower rates of common mental disorders. Conversely, where unit cohesion was considered to be high, there was an association with higher levels of alcohol consumption amongst regular personnel, whilst reserve personnel, who felt they could talk about personal problems within their unit had a lower associated level of alcohol consumption. These findings go some way to exploring the need for senior staff to take an active interest in their staff and inform them as much as possible as these appear to be modifying factors in mental health outcomes for their staff. This research also highlights differences between regular and reserve members of the armed forces and the effects of unit cohesion and morale on them.

In the second of the three papers concerning cohesion, leadership and morale, Jones et al. (2012), another quantitative study, their methodology was different to Du Preez et al. (2012) as the data collection occurred during deployment in Afghanistan. This is significant in that the subjective experience was immediate rather than based on recall. In addition, the nature of the operation in Afghanistan is considered to be more dangerous than the situations faced in Iraq. There is the risk of 360 degree fighting (fighting coming from all sides rather than from specific locations) as well as the threat of improvised explosive devices (IEDs) which have claimed many lives during this conflict.

As with other studies such as Hacker Hughes et al. (2005) common mental disorders and PTSD prevalence rates were similar the general UK population and being in a combat zone did not

necessarily lead to raised incidences of these disorders. If the person had been involved in direct combat, the incidence rates did rise. Interestingly, where leadership, unit cohesion and morale were marked as strong, there was less self-reporting of common mental disorder and PTSD. Various factors were considered in relation to these findings including strong leadership skills which encouraged help-seeking when personnel were facing personal issues. This was the converse of the previous study where poor leadership was associated with higher rates of PTSD and common mental disorders. It was postulated by Jones et al. (2012) that strong leadership might also be helping to reduce the effects of stigmatization of mental health issues, thereby reducing issues before they are allowed to escalate. The possibility that the need for resilience and a strong outlook under situations of high stress might also have been factors in reporting fewer common mental disorder issues or symptoms of PTSD although causality was not assumed. Cohesion was addressed as the most important factor in low levels of reporting symptoms of common mental disorders and PTSD along with leadership reducing issues of embarrassment of discussing personal problems with colleagues.

The final paper being considered here with regards to cohesion, leadership and morale considers objective childhood adversity factors which pre-exist military service (Murphy and Sharp, 2011). They noted a growing body of research linking negative childhood events with increased rates of mental health issues including PTSD. The research was considering an association with morale, which is also associated with mental health issues. To reduce the possibility of subjectivity regarding adverse childhood events, only objective measures were used such as spending time in care and being suspended or expelled from school. Morale was measured in terms of unit cohesion, including items such 'Could Not Talk to Anyone About Problems' (Murphy and Sharp, 2011, p.15) and leadership variables included items such as 'Seniors Not Interested in What I Did or Thought' (Murphy and Sharp, 2011, p.15). In addition, service factors such as 'socio-demographics, role within unit, deploying as an individual or within a formed unit, and enlistment status (either regular or reservist)' (Murphy and Sharp, 2011, p.15) were analysed with the other data using multiple logistic regression models.

The main finding from their results was that service factors played a more important role in determining unit cohesion and, therefore, morale over pre-existing adverse childhood factors. Further findings included that women, reservists, lower ranks and non-combat units reported lower levels of unit cohesion as well as lower regard for leadership. With regards to age, as the participants age increased, there was increased regard for leadership, as participants felt their seniors were paying them more attention. However, they also felt less able to talk with colleagues about issues that were concerning them.

Two particular associations which are highlighted by Murphy and Sharp (2011, p.116) may be of interest to psychologists working with service personnel and veterans. There was an association between believing that seniors were not interested in the work of juniors and four out of the five childhood adversity statements. The second association of note is between low levels of perceived unit cohesion and the childhood adversity of truancy. Both of these associations may need to be considered in terms of CBT core beliefs and negative automatic thoughts in counselling sessions, as well as considering how these beliefs and thoughts might effect the therapeutic alliance.

B7 Research Regarding Interventions (including some American Studies)

The next group of research papers are concerned with interventions offered to minimise the negative effects of deployment and combat experiences. There are a multitude of studies, including non-UK research, regarding interventions including work by Monson, Schnurr, Resick, Friedman, Young-Xu and Stevens, (2006) who conducted a study of ex-service personnel (n=60) using cognitive processing therapy – a blend of CBT and exposure therapy. Their results showed a promising improvement in fifty percent of the sample in symptoms when assessed one month after treatment, although the author of this review would be interested to know symptom levels, for example, one year post-treatment.

A meta-analysis of psychotherapies was conducted by Benish, Imel, and Wampold (2008), which sought to improve on earlier meta-analyses exploring the efficacy of psychotherapies, did not yield conclusive results. In another study, Schottenbauer, Glass, Arnkoff and Gray, (2008) discovered high non-responsive rates as well as high dropout rates but argued that using psychodynamic approaches should not be ignored as they can be effective in complex cases. The author of this review notes that neither of these studies were directly related to CR-PTSD, but found them to be informative, nevertheless.

Following evidence that behavioural family therapy aided the long term reduction in symptoms of severe psychiatric disorder, Glynn et al. (1999) used these techniques alongside exposure therapy (discussed below) to see if there was a similar effect for PTSD. The reason for including this study is not so much for the results of the therapy (a reduction of positive symptoms but no lessening of negative symptoms), but rather because of the problems identified such as high drop-out rate of participants; difficulties experienced by the participants in including families at highly emotional sessions; and not including a behavioural family therapy factor without the

exposure therapy. The author of this review notes the necessity for thorough preparation and consideration of these factors before any research is even developed.

Another intervention considered by Sherman, Zanotti and Jones (2005) looked at the implications of including a partner in the therapeutic process of ex-service personnel who have PTSD. Their paper considers the importance of relationships and they discuss a potential new framework in which couples therapy might operate. This includes work on re-experiencing symptoms and how the partner can understand and assist the sufferer; increasing understanding of avoidance behaviour and how the partner can connect with the sufferer and provide support; and finally, working with increased arousal of the sufferer. Much of the recommendations are based on a reduction in stress within the relationship caused by factors outside of the relationship.

An innovative case study, following in the footsteps of internet-based CBT programmes, used a “virtual environment” (Gerardi, Olasov-Rothbaum, Ressler, Heekin and Rizzo, 2008, p209) to provide the necessary cues for exposure therapy. This case study examined American service personnel experiencing the environment of Iraq virtually, eliciting fear responses and guiding the subject to effective processing of those fears. The results were shown to be clinically significant and plans are underway to increase the size of the study and conduct trials with larger sample sizes.

In a study that was conducted with soldiers without a formal PTSD diagnosis, it is interesting to note that imagery rehearsal therapy (changing the scenario of a nightmare, writing down the new version and mentally practising the new version whilst relaxed) led to a reduction in nightmares, PTSD-like symptoms and insomnia in a small study (n=11) of service personnel in Iraq (Moore and Krakow, 2007).

In the last of the American studies being reviewed in this section, Taylor, Thordarson, Maxfield, Federoff, Lovell and Ogrodniczuk, (2003) produced interesting results in a comparison study of exposure therapy, EMDR and relaxation training which showed that exposure therapy achieved better results than the other two therapies which did not differ much from each other results-wise.

From the UK research, one intervention that has been studied is the role that briefing and debriefing might have on mental health issues. Although the current viewpoint regarding debriefing is that it should be avoided with regards to PTSD in general (NICE, 2005; Mayor, 2005), the role of briefing and debriefing for service personnel is still being researched. The

reason for this is, unlike a member of the general population who is not expecting to be faced with life-threatening situations as part of their day-to-day living (1-2%), because of the nature of the occupation, service personnel are more likely to face these kinds of situations –up to 30% (Deahl et al., 2000). This older study by Deahl et al. (2000) was concerned with primary and secondary prevention measures and tertiary interventions. Primary prevention measures included a screening programme of individuals who might be susceptible to PTSD on deployment who were offered preparation and training sessions prior to deployment. Secondary measures included brief techniques which would be made available immediately or shortly after a traumatic experience. Tertiary interventions followed conventional treatments such as CBT. Although the sample size was small (n=106), the authors found lower levels of PTSD post-deployment. In comparison with troops deployed before the pre-deployment training package was introduced, up to fifty percent less reported PTSD symptoms.

Mulligan, Fear, Jones, Wessely and Greenberg (2011) produced a meta-analysis – a rare piece of qualitative work amongst a plethora of quantitative studies – to consider the effectiveness of psycho-education as a briefing tool before deployment to conflict zones. Their findings of the various studies they considered were that, although some programmes of psycho-education appeared to indicate a positive outcome following this type of briefing which was of benefit to those in attendance, there were inconsistencies in the delivery of programmes. Added to this, benefits were not always noted in some of the research under investigation. Rather than rejecting this type of briefing tool, the authors suggested that further studies which were similar in process and outcome variables be studied in randomised controlled trials (reverting back to quantitative research) so that comparable data could be explored. There is concern that future studies be ‘methodologically robust’ (Mulligan et al., 2011, p.12) in order to fully assess the efficacy of psycho-education as a briefing tool which helps to minimise the effects of potentially traumatic events (Mulligan et al., 2011, p.1).

Two recent UK studies have examined the role of decompression for forces returning from overseas deployments (Fertout, Jones and Greenberg, 2012; Hacker-Hughes et al., (2008) which has been used instead of briefing and debriefing. Decompression is described by Hacker-Hughes et al. (2008) as the release of pressure which may have built up during overseas operations. They reviewed literature regarding this procedure which appeared to begin during the Vietnam conflict, where soldiers were removed from the front line and offered time away to relax and recuperate. Nowadays, decompression is used at the end of an overseas tour, often following conflict or peacekeeping tours, in order to help returning service personnel to adapt to UK life away from the front line. The purpose of the review was to examine the

effectiveness of these decompression periods since, at the time, little research had put forward positive evidence of the effectiveness of decompression.

Hacker-Hughes et al. (2008) noted that various countries ran decompression periods in different ways, and indeed, these times were variously known as third location decompression (TLD) and normalisation. For some service personnel, these times were considered to be of benefit in blowing off steam and allowing them to distance themselves from high-stress occupational areas and readjust to returning home. However, Hacker-Hughes et al. also reported that for others, this period of normalisation was considered a waste of time and they would have preferred to return home immediately. The UK period of normalisation also offered the leadership a chance to have post-operational debriefing sessions which included psycho-education about the effects of stress, monitoring of staff who were displaying potential symptoms of PTSD and official ceremonies thanking all personnel for the involvement in tours.

In terms of the effects of decompression on mental health, Hacker Hughes et al. (2008) found relatively few quantitative studies to work on. What was found showed that when troops were kept on bases for more than two weeks post return from deployment, the incidences of reported mental health symptoms increased compared with troops who were kept on bases less than one week after return. They concluded that, whilst there was no official protocol for the format of decompression periods which would be based on empirical evidence for their efficacy in reducing mental health issues, these periods should remain discretionary, not mandatory.

Fertout, Jones and Greenberg followed this study of relevant literature with a quantitative study of decompression (Fertout et al., 2012). By this stage, the term TLD was the preferred nomenclature and they reported evidence to support TLD in reducing potential mental health issues following deployment in high combat tours. The Fertout et al. (2012) paper was concerned with evaluating the TLDs for individual augmentees (IA) who were deployed separately to their units. Under consideration was whether they would gain any benefit from the TLD without their unit being present. Fertout et al. included data from formed units (FU) to compare relative experiences.

The desire to participate in the TLDs was higher in the FU (60%) compared to IA (30%) prior to going, although 78% of the IA reported high levels of satisfaction after completion of the TLD. Following completion, the FU reported lower satisfaction levels but at greater numbers (84%). Fertout et al. concluded that all personnel should be offered the chance to attend TLD and that IAs should not be excluded as they gained as much as the FU. In addition, those personnel who

were considered at greater risk of suffering from symptoms of mental distress and combat-related PTSD should be encouraged to attend the TLD. For this group, it was observed that the TLD was an aide to adjusting from high stress levels experienced on operations compared to situations after deployment.

B8 Research regarding Mental Health Issues and Deployment

Prior to 2007, a study by Rona et al., (2006), funded in part by the MOD, who used a longitudinal study of British forces to test any connections between existing mental disorders and subsequent disorders including PTSD. However, they found screening was not a useful predictor for the onset of later mental health issues. The MOD-funded study by Hacker-Hughes et al. (2005), mentioned earlier, did not agree with the findings which indicated the latest deployment of troops to Iraq would lead to similar issues that had been experienced after the conflict in Vietnam due to developing preventative measures and increased awareness. The findings may be due, in part, to issues such as differing types of operations but may also be due to methodological differences such as length of time to follow-up assessments and differing baseline prevalence measures.

Wilson, McAllister, Hacker-Hughes and Fear conducted a short study into the perceptions of current armed forces personnel receiving counselling from staff dressed in military uniform. The study was concerned with the readiness of clients to discuss problems relating to military service with someone who was dressed in a uniform which designated them as part of that military establishment. Whereas a qualitative study might have made use of peoples experiences, perhaps using a statistical method such as narrative analysis, interpretative phenomenological analysis or grounded theory to investigate the person's experience (for example, Willig, 2001), the authors used a quantitative research method of a short questionnaire from which simple statistics were produced. The results did not show any significant preference for counselling staff to be dressed either in military uniform or civilian clothing. If this study had been qualitative instead, the results may have proved more valuable to those working with this client group.

The final KCMHR publication being considered here in this literature review is concerned with the perception of experience of being deployed in Iraq and subsequent mental health issues (Sundin et al. 2010). As with the majority of studies from KCHMR, this research relies upon quantitative research methods rather than qualitative ones. The subject matter – people's experiences – lends itself to a qualitative method. However, statistical analyses including

Poisson Regression were used to compare and consider associations between a multitude of variables. Associations with rewarding experiences occurred with variables such as “doing the job trained to do” (Sundin et al., 2010, p.659) and “teamwork and comradeship” (Sundin et al., 2010, p.659). Unrewarding experiences were associated with variable such as “being separated from family and friends”, “quality of immediate commanders”; other and the “physical conditions of theatre” (all Sundin et al., 2010, p.659).

B9 Going Forward

Diverting away from UK research briefly, a study published in 2008 assessed the well-known and significant effect of anger on CR-PTSD sufferers (Forbes, Parslow, Creamer, Allen, McHugh and Hopwood, 2008). The reason for including it in this discussion section is the implications of dealing with anger in a therapeutic setting and therapeutic outcome. The study found that counsellors needed to address the issues of anger as well as aggression and alcohol use if therapy was to be effective. The author of this paper considers these issues to be significant barriers which would need to be addressed in any research which was being considered.

A second non-UK paper which can be considered important in terms of influencing potential research design is similar to Forbes et al. (2008) in addressing behaviours and emotions. Miller, Fogler, Wolf, Kaloupek and Keane (2008) analysed correlating factors including anxiety, misery, major depression, fear, antisocial personality disorder, obsessive-compulsive disorder and substance abuse/dependence with CR-PTSD. Considering these factors which can be internalised and externalised (Miller et al., 2008) and the effects of co-morbidity, it seems to the author of this review to be essential to understand the client’s presenting issues fully to ensure treatment offered to sufferers is staged, dealing with certain diagnoses first in order to then offer therapies for the other diagnoses. An example of this would be to address substance abuse/dependence issues before being able to consider PTSD (Hoge et al., 2004).

One area where the author of this review believed there was a gap in research was with regards to the language used by service personnel. In light of the findings of various studies and reports discussed earlier (Bilton, 2007; Gale, Marquez, Al-Khudhair, Saftis, Knottley and Azua, 2006; Gould, 2007), the need to understand the language styles used by this population was considered a worthwhile area of study, especially for counselling psychologists who do not share a military background with potential clients. By understanding the language styles to a greater depth, the counsellor may be able to overcome the lack of service background.

In particular, going forward, I believe that the dearth of peer-reviewed published qualitative research regarding the UK's armed forces and veterans is to the detriment of these clients. By encouraging, wherever possible, qualitative research to be conducted will surely add depth and wider understanding particularly to those working in counselling settings with these client groups. Although statistics can indicate associations, epidemiology and outcomes, qualitative research adds to the psychologist's empathic tools when working with these people.

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Section C Clinical Work

Working Around a Defence Mechanism during a CBT Counselling Session

C1 Rationale for the work

I am presenting this report to demonstrate a developing understanding of commenting on process within counselling sessions to positive effect with a client with social phobia⁴. In addition, I explore using transference, normally associated with a psychodynamic approach but gaining greater recognition in cognitive behavioural therapy (CBT) settings (Milton, 2001), to gain insight into potential parallel processes occurring for my client reflecting childhood experiences, adult relationships and within issues she is facing.

C2 Theoretical framework

Social Phobia

Clark and Wells (1995) suggest a model of social phobia (Figure 1), where the client processes themselves as a social object when facing social situations, assumptions are activated and the situation is perceived as dangerous. The self receives information from behavioural symptoms as well as somatic and cognitive symptoms which influence the self in its processes as a social object.

⁴ In accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 2000) I have used the term Social Phobia, although other authors referenced in this report use the term social anxiety. For this report, I am considering them to be relating to the same construction.

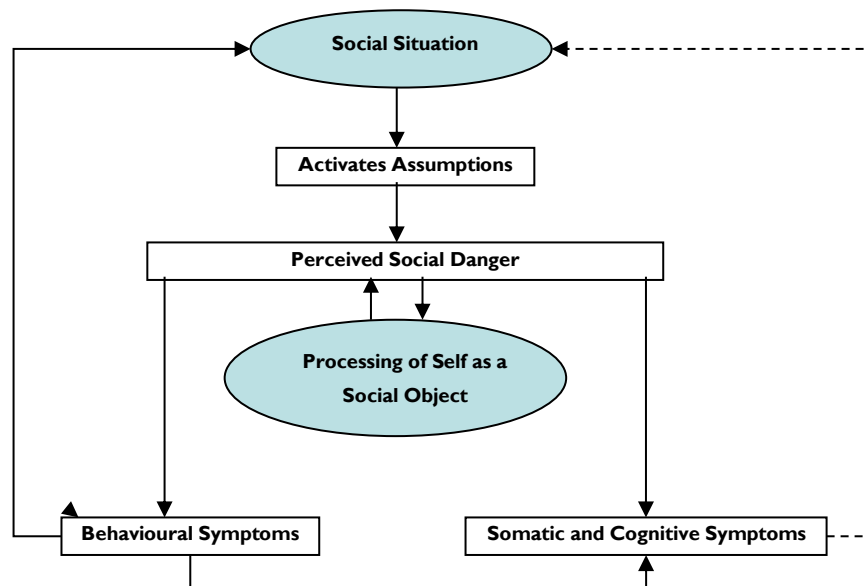


Figure 7 Clark & Wells (1995) Social

Moscovitch (2008) goes further in his proposed model (Figure 2) which centres around the socially anxious person’s central belief that their character is “deficient” and that others will perceive this deficiency in social situations.

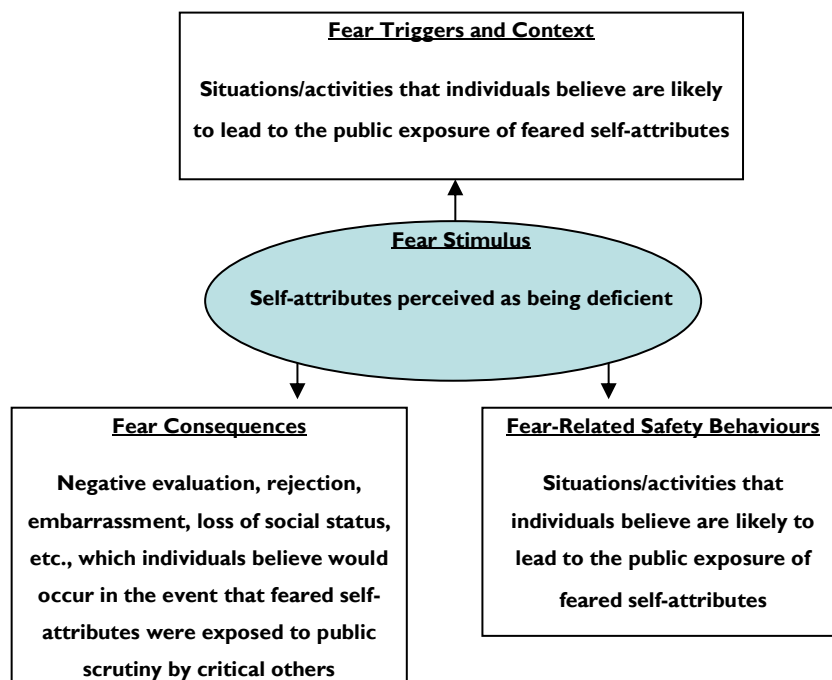


Figure 8 Moscovitch (2009) Proposed model of the feared stimulus and functionally related clinical sequelae in social anxiety.

Using this model of social phobia, Moscovitch identifies key areas to be targeted in therapy including using examples of feared situations to “assess anxiety symptom profiles” (Moscovitch, 2009, p.129), persuading the client to challenge the social norms they hold as well as how much

infringing these norms can really affect them, and encourage the client to consider the reactions of others to the self – turning the reaction from critical to more viable reactions.

Cognitive Behaviour Therapy

Both models described above are framed within a cognitive behavioural paradigm, which developed from Beck's cognitive therapy (Beck, 1976). Issues facing clients were discussed in terms of thoughts (cognitions) affecting and being affected by feelings, behaviour and somatic reactions. By unveiling these cognitions through guided discovery and other techniques (Beck, Emery and Greenberg, 1985), the therapist aims to facilitate change for clients who can challenge their own thoughts and try out behavioural experiments to alter their reactions to issues they are facing.

Transference

Transference, that is using the occurrence of the client's experience of significant others expressed in the therapy room in terms of the relationship between the client and therapist, is being used explicitly used more often within CBT work (Miranda and Andersen, 2007). Milton (2001) argues for the inclusion of transference within CBT sessions as CBT develops from being a step-by-step instruction guide to a more "constructivist" therapy – allowing the client to construct their own reality through therapy. By commenting on transference, it is thought the therapist can lead their client to a greater understanding of the development of the issues they face (Miranda and Andersen, 2007; Milton (2001).

C3 Profile of client

(a) Personal details

Gloria⁵ is a forty-six year old, English, Caucasian female, divorced for two years, after a twenty year marriage. She is financially supported by her divorce settlement, does not have a paid job, volunteers for local groups and attends a music appreciation course in order to meet a potential partner.

⁵ All names and identifying information has been changed to preserve confidentiality for the client.

Key family members include two adult children and one younger brother. Her father died some years ago, and her mother, with whom she had a difficult relationship, died in the previous year.

Gloria describes 'a reconciliation' with her mother before her mother's death and reports feeling peaceful about the bereavement. She reports still feeling shattered after a relationship ended in December last year as she contracted a sexually transmitted disease (STD) through her ex-partner which is not curable. She considers this to be unfair as she has only had three sexual partners in her life.

She described her mother, her ex-husband and her ex-partner as controlling characters and reports feeling de-skilled in making decisions.

My impression of Gloria is of an artistic character, reflected in modern, deconstructed clothing, although her child-like hairstyle did not seem to match her adult clothes. Gloria seemed ready to discuss the issues she was facing, but was often tearful and seemed quite childlike in her expressions in the sessions. She does not seem to hold back information although she has described feeling like a fraud in coming to therapy as her "problems don't seem so bad".

(b) Referral

Gloria was referred by her doctor to the in-house counselling services of a London NHS Primary Care Trust (PCT) group practice. The sessions take place weekly at the practice, in a doctor's consulting room, following a stepped care model approach (Bower and Gilbody, 2005) to increase the efficiency of provision of services and effective therapy.

(c) Presenting problem

Gloria had been experiencing increasing anxiety when leaving her home to engage in social activities.

(d) Initial assessment

I conducted an initial assessment, such as the type described by Kirk (1989). Gloria presented with anxiety when considering social activities, complaining of stomach upsets and indigestion, and intrusive anxious thoughts leading to avoidant behaviour and the employment of safety mechanisms such as meticulous planning of journeys to arrive early at events.

As Gloria's symptoms suggest a diagnosis of social phobia, following National Institute of Clinical Excellence (NICE) guidelines on anxiety (NICE, 2007) she was recognised as having an anxiety disorder (step 1) and was offered psychological therapy, particularly CBT, in a primary care setting (step 2). CBT has been shown to be effective in reducing the effects of social phobia (Hoffman and Ott, 2008; Butler, Chapman, Forman and Beck, 2006; Clark, Ehlers, Hackman, McManus, Fennell, Grey, Waddington and Wild, 2006; Clark, 1999).

Using measures required by the group practice, Gloria was assessed using CORE-10 scoring 1.2 in the moderate range. In addition, using the GAD-7 tool, Gloria scored 7, in the mild range.

(e) Contract and psychological counselling plan

After assessment, we agreed to meet on a weekly basis for up to six sessions (maximum allowed within practice protocol), using CBT techniques to address social phobia. The client agreed to complete tasks between sessions with the goals set for reducing the impact anxiety was having on Gloria's social engagements as well as encouraging Gloria to connect with her current thoughts and feelings, through the use of ACT techniques. Gloria's long term aim was that by reducing her social phobia, she would be able to pursue her goal of developing a lifelong romantic relationship.

C4 Case Formulation⁶

I hypothesise early experiences such as a controlling mother who imbued a belief that the expectations of others were more important than self-efficacy, led to core beliefs such as 'I must be perfect to be liked'. These beliefs have led Gloria to believe that she will be considered the odd-one out in social settings, that no-one will like her and that she has nothing to offer others. These fears of social situations, activated assumptions and processing of self leads to avoidant behaviour and the use of safety mechanisms to reduce her social phobia, although the effects are somatically experienced in stomach upsets as well as intrusive, ruminating thoughts about her performance in social settings.

C5 Lead-in to session

⁶ Please see Appendix A for diagrammatic representation of the case formulation.

The third session has just started and I am checking with Gloria about her homework tasks from last week – a hot thought record which she was finishing off from our second session, plus continuing an exercise of using her art skills to express thoughts, feelings, memories and sensations⁷. She had successfully used this exercise the previous week, but when she started talking about it in the current session, her voice changed, reminding me of a child's voice, and she told me she had struggled with this exercise this week and hadn't completed it because I had told her previously she didn't have to.

C6 Transcript⁸

Key to Transcription	Co	Trainee Counselling Psychologist
	Cl	Client
	Com	<i>Trainee Counselling Psychologist's subsequent comments on session</i>
	(pause)	Period of silence usually longer than two seconds
	{word/mm}	minor intervention
	Bold	Emphasised spoken word

Co I I, er, er, as we're talking about this, I am really reminded of when, when we first met, erm, and you were telling me that, with, say with your relationship with your mother and then with your ex-husband and then with your ex-partner, that you felt that each of them had been quite controlling. And I remember feeling, I think after, it, it was either after that first session, I felt that I had told you to complete a task. And I almost felt as if I had almost put myself in the role of someone who was going to put some control onto you. And I think when I said to you, it was probably last week, that if you didn't complete it, and it was up to you, I think, I was very aware of not wanting to continue {mm} maybe in a controlling function. {mm} in the way that maybe some of your other relationships have been. And maybe that has, maybe actually, when you got

⁷ This exercise comes from acceptance and commitment therapy (ACT), considered a third wave development of CBT, which is considered to be as useful as CBT in treating social phobia (Harris, 2008; Forman, Herbert, Moitra, Yeomans and Geller, 2007; Orsillo, Roemer, Block-Lerner, Lejeune and Herbert, 2004).

⁸ The recording has some background noises that were unavoidable due to the counselling setting. The noises include a computer ventilation fan which can be heard every few minutes, plus a GP calling in patients to a room opposite the counselling room.

to Sunday evening and you had this sort of crisis, I'll call it a crisis {yes} I mean {yes maybe that's a bit sort of over the top

Com 1 *I was feeling cross with Gloria – not only had she managed to do this homework the week before without instruction, but also, her voice reminded me of a little child and it felt as if she was putting me in a controlling mother's position to her little girl's position. I also felt she was trying to present herself as helpless, although I knew she was a very capable woman. In addition, I felt she was trying to blame me for not completing the task, which annoyed me. I remembered feeling like this before at her assessment and had wondered between then and now if I should say something about how I had felt controlling in giving her homework in the first week and to counteract this, I had said it was up to her if she did the tasks. I had not spoken up initially, since the idea of transference is more commonly associated with a psychodynamic approach in counselling. Having read more about using the effects of transference within CBT sessions (Miranda and Andersen, 2007), I was more inclined to include my earlier experience in this intervention.*

I was also reminded that within the therapeutic setting, process consists of what is going on for the client, both within and outside of the therapeutic session; what is going on for the therapist, again within and outside of the therapeutic session; and finally what is going on between the therapist and client. Counselling psychologists are trained to consider commenting on these processes as they can provide invaluable insight for clients as to their behaviour both within and outside of the therapeutic setting.

In order to try not to carry on the feelings of transference of a potential mother-child relationship in the therapy room, I tried to talk to her as an adult, one who was not trying to control the situation, although I recognise that this intervention was more to do with my agenda of working with process, rather than Gloria's possible agenda of wanting to feel supported as a child in the situation. I did not believe that the intervention would disrupt the therapeutic alliance, but would challenge my client to realise that we would be considering more than just content in the session.

CI 1 It has been hanging over me all week and I've sat down and you know, just haven't known where to begin.

Co 2 So is that, it has made you feel really quite uncomfortable? {mm} erm and in a way, the focus has been very much away from you and what you might, er, set for yourself and really more about the exercise was {indecipherable comment from client} about how I, {yeah} you were wondering about how I would respond to it.

Com 2 *Once I had made the intervention at Co 1, I felt more positive about using the intervention. I heard Gloria's voice wavering in Cl 1, almost tearful and she physically looked uncomfortable, squirming in her seat, I believe in my recognition of how she must have been feeling. I wanted to keep concentrating on the experience, rather than the content, as well as tying this emotion plus body sensations into her real motivation for carrying out homework. With someone with social phobia, the person strives to achieve results not for themselves, but as a means of performing for others (eg Hoffman 2007; Moscovitch, 2008). My agenda for Gloria was for her to recognise how she feels when she is trying to impress others rather than trying to achieve goals for herself. I also wanted her to realise that I saw she was doing the task for me, not for herself and wanted her to explore how that had felt.*

Cl 2 Yeah, yeah, because I feel like I haven't done what I was asked to do and, you know, I would have, it's not something I would ever set myself to do, I don't think. (mm, mm) And so (pause), yeah, and I do feel a lot of my life is like that, it's, it's what other people want me to do, and you know, I sat down this morning, I woke up this morning and I was very anxious when I woke up, cos I'm, I hate wasting the morning, you know, if I woke up after eight o'clock say, I would be, I would be very anxious because I would feel I had wasted a big part of the day and there are all these things that I've got to do, erm, (pause) none of which really are things I want to do, now, I mean, it's a bit like work, isn't it? You do things you have to do and they, they are imposed upon you and that doesn't leave you much time for actually doing what you want to do (mm) And, er (pause) yeah, life is a bit like that, isn't it, although, you know, I don't work, I should be having a lovely time but there's th', there's this underlying feeling that, erm (pause), I, er, I'm quite anxious all the time because, I don't know why, it's crazy, it's completely crazy (laughs) (mm) erm, (pause) and I don't know if that is the expectation of myself or what I think that I project onto other people, you know. So I suppose I have been brought up to think, you know, care about what other people think about me (mm) and it was.

Co 3 It was a strong, when you were talking just about how, because you hadn't done the, the, trying to express your thoughts through painting, it about, it was the concern about how I would react with it (mm, mm) and if you are in bed till eight o'clock in the morning, or nine o'clock, it's a waste because you are, you feel like you are wasting it or other people will view you as wasting that time?

Com 3 *Through Cl 2, I have not interrupted Gloria apart from a few "mm's" because it seems as if my intervention at Co 2 has touched a chord with Gloria and I want her to keep exploring her*

thoughts about other's imposing control on her. Whilst I am listening to her, I am also making a mental checklist of things that might be important to bring up (such as discovering her desires/rules rather than others; exploring emerging core beliefs), which can sometimes seem distracting, but I want to make sure I remember them, either for use now or throughout the session.

In Co 3, I want to emphasise what I think Gloria has just said to me, that she was doing the homework for me. I then use the last part of the intervention as a question – challenging Gloria to confirm whether she believes wasting time is unacceptable for her or because of a performance anxiety that others would consider behaviour unacceptable. My intention is to tie in her behaviour with the way people suffering from the symptoms of social phobia relate their behaviour to others rather than to themselves (eg Beck, Emery and Greenberg, 1985; Butler, 1999).

CI 3 (pause). I think that's more me, cos there's nobody else to see that I get up late in the morning but, erm (pause) I don't know. These tasks, I put on myself to do, erm, I mean I couldn't just get up and read a book (mm) I mean I, I do Sudoku puzzles over breakfast because I enjoy doing that, but, but I have to sit down to eat my breakfast so that's my way of waking up my brain (laughs) in the morning, I suppose. Erm, (pause) but then it is entirely up to me what I do in my day, but then I spend most of my days sitting at my computer, answering emails, doing sort of accounts for my daughter, for myself, for the probate, for the, you know, all sorts of things that I've got to do and, er, it's like, I do I sit at my computer nine to five doing all these things, I'm not saying I don't enjoy, go out and enjoy myself, but, er, it's kind of, I should be able to just sit down and read a book or I, er, sit around doing nothing. (pause) but I don't (laughs).

Co 4 What would it, I wonder it might, what, you might think about doing nothing for a while? What, er (pause)

Com 4 *It seems to me that Gloria is trying to provide me with evidence that she is doing things for herself, but from time to time, I hear hesitation in her voice as well as content that seems to be about doing things for other people. Also, I hear Gloria laughing from time to time, I do not think this reflects happiness, but rather using laughter to release feeling uncomfortable with her thoughts regarding doing things for other people.*

Butler and Hackman (2004) suggest experiments where the client drops safety behaviours to test their anxiety, and I wonder if Gloria's 'activities' are being used as safety behaviours,

hence challenging her what it might be like to not do them. I use a challenge style of intervention (Egan, 2007) in Co 4 to see if she could recognise this discomfort, possibly caused by an emerging core belief – ‘I must do things to please other people in order to be liked’ – and her own desires to please herself. In using challenging, my intention is that Gloria will start to use the tool of challenge for herself, in checking her thoughts in anxiety-provoking situations (Butler, 1999; Kennerley, 2006). Longmore and Worrell (2007) question a need for challenging thoughts in CBT as they reveal there is little empirical evidence that challenging thoughts effects an amelioration of symptoms (pp.173). Bearing this in mind, would I continue to use challenge of thoughts in future sessions. At the time, I considered it a useful tool in order to press Gloria to consider her thoughts.

- CI 4 I’m not sure I could. (er) I would have to be reading or doing some puzzles or something like that.
- Co 5 So the thought, the, the, I don’t know if you can try and tell me some of the thoughts that might be running through your mind at the moment, if you think about doing nothing for a moment.
- Com 5 Gloria seems to resort to her normal activities as a thought and initially I am tempted to just confirm this back to her. Although the challenging might seem strong, I believe that Gloria is resisting the challenge due to discomfort rather than because she cannot explore these thoughts at the time. I have a picture of myself as a terrier dog which will keep digging to get to its goal and, for myself, having started on this path of exploring transference and parallel process, I do not want the interventions to end up in a dead end, so carry on with the challenge. My intention is for Gloria to make some connections between her behaviour and her core beliefs, although at this stage, these concepts have not been explained to her. By repeating the challenge of Co 4 in Co 5, I also bring the question into the present moment, to see if Gloria can explore how she feels about the thought in the here and now.
- CI 5 mm, (pause) I would probably think I was being very naughty, I mean, wasting time, and all of those things would be piling up and, you know, that would make me feel even more anxious, I suppose.
- Co 6 Would it be, would it be your judgement on you thinking that you are naughty or, or, if it was somebody else’s judgement?

Com 6 *The word “naughty” and my perception of Gloria’s voice tone changing from adult to child jars against me and initially I feel annoyed that Gloria seems to resort to childish behaviour and language when responding to me in this adult setting. I recognise, however, that this is another type of parallel process occurring, bringing the roots of her core beliefs into the therapy room as a mechanism for me to see where her behaviour stems from. At another time, I could have used this change in voice tone and use of childish words to draw Gloria’s attention to her use, to aid her understanding of the origins of her core belief, that in childhood, people would think she was naughty for wasting time. However, in the moment, I decide to use her word “naughty” in attempt to discover if Gloria herself feels this is naughty, or if she is looking to external sources to rate her behaviour (Moscovitch, 2008). I remember, in the moment, struggling and not wanting to use the word “naughty” as it seemed childish to use this word, but I wonder, on listening to this intervention, if using the word was a positive thing to do as it seems to reflect the distance between the child and the adult.*

Anderson, Goldin, Kurita and Gross (2009) found that people suffering from symptoms of social phobia tend to use “more self-referential, anxiety, and sensory words, and made fewer references to other people” (pp1119) when talking about social anxiety. In asking Gloria about other people’s opinions, I wanted to test the theory that she is processing herself in how she thinks others view her.

CI 6 (pause) Well, I suppose it must be mine, because there’s nobody else there to see. (mm) Although I suppose, you know, if somebody else, like my brother maybe said, have you done such and such and I said, no, I wouldn’t have an excuse to say why I hadn’t done whatever it was I was supposed to be doing (mm). (pause). I think, I mean, this came out in my therapy before that I am quite hard on myself (hmm) you know, I’m a bit of a perfectionist and want everything to be kind of perfect, and that includes how I see myself (mm) which is way off (laughs) being a perfect person (laughs) (mm) erm.

Co 7 In, in terms of being a perfect person, what, what are the advantages of being a perfectionist?

Com 7 *During CI 6, I notice Gloria begins to use silence to work on her thoughts – as she sits in front of me, I see her eyes moving from side to side, indicating her active thought processes - and I am keen not to interrupt her. In hearing her response, I feel pleased Gloria is recognising her behaviour is based on her own judgement and that this has then triggered a memory of her desire for perfection.*

My intervention at Co 7 follows my own agenda as the mention of perfectionism reminds me of an exercise that Clark (1989, p.88) describes which is designed to help the client realise that disadvantages can outweigh advantages to perfectionism, and facilitates the client in identifying assumptions lying behind perfectionism. An alternative, which may have followed Gloria's agenda, could have been to ask her about the differences between her behaviour and the excuses she felt she had to make. On re-listening to the session, I believe that the route taken was effective in helping Gloria to explore a variety of beliefs and assumptions, which was the intention of using the Clark intervention.

CI 7 I suppose it's being in control, isn't it. (pause). Erm, (pause) I suppose self-satisfaction (pause) erm, (pause), I don't, I kind of, I kind of, erm (pause) make that okay in my head, in that, that's how I want to be (mm). I know people who, you know, are very messy, and leave the washing up for a week or whatever and, but that's not me. I mean why should I do that if I want to, it's not hurting anybody else, I mean, I don't impose my perfection on other people, I don't think. (pause) And I used to say, I used to say, when my daughter lived with me, er, and she might leave some washing up, and I would say, look, I'm only doing this because I want to, it's no reflection on you, (mm) you know, I li, if you don't want to do that, that's fine with me, but I actually like to have a clear space, (mm) in order to cook or whatever (mm), so I'm doing it because I want to (pause) so I can justify it (laughs).

Co 8 So there's some, there's some justification and also feels like some positives be, because it, it helps you feel like you're in control and it gets the things done in the way you want them to be done

Com 8 *In order to carry on with the intervention from Com 7, I use Gloria's response in CI 7 to provide her with an example of the advantages of perfectionism, I am also mindful that a client's behaviour must not always be seen as negative, and I want to provide her with some positive affirmation that her behaviour can serve a useful purpose. My intention in Co 8 may be to offer Gloria some positive relief from the challenges I have been presenting her with, although I realise this could be received by Gloria as praise for her behaviour, and therefore, a continuation of external cues for her behaviour. In the moment, however, I believe my intention was to clarify advantages so that Gloria could view perfectionism in a balanced way and not adding it to her negative behaviour. I am also reminded of Leahy's (2005) work on validation – discovering a truth for a client even though that truth may be “a distorted or a biased set of rules” (pp.195).*

By repeating back to her with added information that this might be viewed as an advantage to perfectionism, I wanted to reinforce what could be seen as positive behaviour.

CI 8 mm, I suppose it does also stop me doing other things though. Because, you know, I have to wash up before I can start cooking

Co 9 Right

Com 9 *I was surprised that Gloria had already thought of a disadvantage, as I had imagined I might have to work with her on drawing negatives out – it can hard for perfectionists to see negatives in their behaviour due to dysfunctional assumptions (Clark, 1989). My response in Co 9 is an immediate reaction, and seems to be me speaking before I think.*

CI 9 But that's just the way my mind works, I can't cope. Although I don't do that working, I don't mind having mess all over my desk when I'm working, (mm) that doesn't bother me.

Co 10 Okay, so, so it feels , I guess what you just said, almost feels a bit like a slight sort of disadvantage to, to you feeling a sense of perfection or needing to, to have things done in a perfect way. (mm) Are there any other sort of disadvantages you might feel that for yourself from the sense of perfection?

Com 10 *Having jumped in with my response in Co 9, I am keen to keep Gloria on track with considering her perfectionism. I resort to the language I have used previously in Co 7 and 8 in order to present a clear understanding for Gloria in which to frame her thoughts. As I consider this, again, I realise that this is my agenda within the session, that I am keen for Gloria to make connections between her perfectionist behaviour and potential underlying core beliefs which links into her social phobia.*

On reflection, I have also not picked up on Gloria saying that she cannot cope without perfectionism, as she herself then contradicts this by providing a picture of compartmentalised perfectionism. I do not respond to this verbally, but am reminded of feeling Gloria could be using a child-like mechanism to draw me into being the capable, controlling adult in the session to her helpless child. As I have fought taking on this role overtly, I am continuing to do so. I wonder, however, starting the session with a reflection of this type, if I had commented on these feelings throughout the session, what the impact of this might have been on Gloria.

This may have presented her with more evidence of how she tries to cope in stressful situations, which is possibly how she viewed the session.

CI 10 Well, it, it, it takes away my freedom, in a way, to think, I think, you know, to actually just be and experience thought and (pause) because it's always (pause) have I done this, have I done that? You know, am I being the person I want to be in my head. Erm.

Co 11 Who is the person you think you want to be in your head?

Com 11 *The unfinished homework task was intended to aid Gloria in touching base with herself in the moment, to recognise thoughts and feelings⁹, and here, Gloria appears to realise that her drive for perfectionism is getting in the way of how she experiences herself. By using a Socratic question (Kennerley, 2007), asking Gloria to describe the type of person she wants to be in her head, I am hoping Gloria will be able to express more about who she thinks she ought to be in order to explore her underlying beliefs about who she should be.*

CI 11 (pause) a perfect person (pause) who does everything right and everybody loves and you know, is pleasing, I suppose I want to please everybody (pause) including myself, and, er, (pause) is someone that's just, everything kind of flows and everything's lovely. And it, it doesn't exist, this person (laughs)

Co 12 It sounds like a tall, a tall (big), a tall (yes) order for someone, I was, I was wondering if you knew of anyone who even came close to that.

Com 12 *I am reminded of Moscovitch (2008) describing the central focus of social phobia as the person's self-perception that they are fundamentally flawed or "deficient" in relation to societal norms. As Gloria struggles to get her words out, switching between being on the verge of tears and using laughter again as a way of controlling her emotions, I realise that by using the process right from the start, has meant, through sheer determination on my part, and my client's willingness to stay with me, that we are reaching some deep realisation of how Gloria has been struggling with her perception of herself and how this does not help her in achieving her goals.*

My response in Co 12, for the first time in the session, is much softer tonally and in style. I am recognising that this is a key moment for Gloria, and I want to confirm the impact with my

⁹ using a method from acceptance and commitment therapy (ACT), known as a "third-wave" CBT technique.

words and my non-verbal response, without adding to the challenge of her own realisations. My intention is to convey to Gloria that this type of expectation for any person is very great and I want to see if she thinks that it is realistic, gently reinforcing for her that this ideal person cannot exist and therefore, that she might recognise that the person she imagines to be good enough could not exist.

CI 12 (pause) no. (pause) I don't think so. (pause)

C7 Discussion

In supervision, I have been able to reflect on the influence previous sessions have on future sessions. If I had not initiated an intervention about how a previous session had affected me, the outcome of this session could have been very different. I am aware that Gloria had to work hard in this session, but the end result was a clarification of various factors such as core beliefs and assumptions made about social situations.

Also through supervision, I have been able to consider how I might work with similar clients using the schema mode concept, as proposed by Young, Klosko and Weishar (2003). Where many elements are occurring for a client, as I found with Gloria, by framing the client within the proposed schema modes, this might help with continuing formulation of the issues that she is facing and aid me in developing a therapeutic plan to address these myriad issues.

Working with Gloria has also introduced me to ACT. Hoffman and Asmundson (2007) have compared ACT to CBT and explain that CBT concentrates on cognitions prior to and surrounding issues, whereas ACT places emphasis on emotional response to the issues. By using both approaches with Gloria, I was attempting to facilitate her understanding as well as her experience of social phobia. Although Gloria didn't complete her homework assignment, which can negatively impact on a client's progress (Westra, Dozois and Marcus, 2007), by using her experience of not completing the homework, we uncovered underlying beliefs affecting Gloria.

Throughout this session, I learnt that using process and the incidence of transference helped to facilitate this client's progress in her understanding of assumptions she was making. In my enthusiasm for this new skill, I realise that the session went over the normal fifty minute time period. On reflection, I could have shortened some of the discussions. However, in the moment, I believed it was appropriate not to rush this client in what felt like important realisations. In some ways, I feel justified in this since her progress has led to reported

behavioural changes which the client has initiated, therefore achieving one of the aims of CBT – the client becomes their own therapist.

As I track my progress in training as a counselling psychologist, I am struck how the acquisition of knowledge about new techniques brings greater confidence at the point of being with the client, informing my work and helping me to keep reformulating my clients' presentations in order to ensure I am providing the best possible therapeutic encounter. I found that Gloria has engaged readily, and continued to use these skills in order to understand how she behaves in social settings.

C8 Revisiting the Process Report Twenty Months On

This process report marked a sea change for me particularly in how I considered the use of process within a counselling session. In addition, the use of techniques practiced by other theoretical approaches within a CBT session, aided my understanding of the flexibility I needed to develop if I was to help my clients in their real life situations. As I write this, I am reminded of the classic work by Molony and Kelly (2008) whose article "Beck Never Lived in Birmingham" considers how CBT has been taken up the mainstream health provision as a 'cure-all' for mental health issues, when in fact, as practitioners, as in the session above, there is a need to move away from the CBT protocols. This essay appears in the same collected works book as Milton's essay on the potential crossover between psychodynamic approaches and CBT (Milton, 2001).

On re-reading this work I was first struck by how social phobia could be seen as a chink in the armour of our resilience, of our defences. As negative assumptions are activated and we perceive a potentially stressful situation, as put forward by Clark and Wells (1995), our resilience is reduced and we can be left feeling undefended. In this situation, we rely on behaviours which help us to overcome these negative feelings and return to a more comfortable equilibrium. In Moscovitch's 2008 model, the threatening situation is made worse as the person perceives themselves to be deficient – not having the resilience to cope with a social situation – so their defences are reduced by self-belief as well as by experience. In stressful situations there is a breakdown of the defences of the person against others perceptions of the self.

I then revisited the application of CBT to the treatment of social phobia and how I employed techniques the psychodynamic approach to untangle a situation for this client. In a special edition of the Counselling Psychology Review (BPS, 2010) some seven months after the original work was completed, various issues concerning the contribution of the psychodynamic approach

to counselling psychology were explored. In relation to my work with Gloria, I wondered how her relationship with her mother, which she had described as unhappy and controlled, might impact on the relationship I might have had with her. Indeed, in my commentary within the transcript, I felt Gloria was putting me into the position of mother and, as Laughton-Brown (2010) points out, one of my roles is to provide Gloria with a therapeutic frame which does not follow the pattern she experienced with her mother. I see now that in my commenting on how I felt controlling I was breaking the patterns Gloria had known from her childhood, by making the experience explicit so it could be considered in the present moment.

I also have the sense that this session with Gloria allowed her to be nurtured, albeit through challenge, in developing her trust in me that I would walk with her with these difficult issues. Within this secure space, she was allowed to explore the idea of her safety blanket – a view considered by Winnicott (1988), the need for perfectionism, does not always fulfil its role and this transitioning of closely held beliefs aided Gloria in moving to a less stressful position.

In another provision from the psychodynamic tradition, I see more clearly now how the capacity to act as a ‘therapeutic container’ for Gloria whilst she experienced this transitioning of thoughts, was of key importance. Gravell (2010) considers how this is practically played out by the counselling psychologist (and trainee) both in our own feelings as well as the clients. As I experienced feeling cross (Com 1) I did not allow this feeling to overwhelm me but brought the experience out into the open with the client, thereby containing myself. And for Gloria, she is able to reach a conclusion that perfection does not exist in any person and experience that realisation in a contained way. This is, in a sense, a diversion from the uncontained experiences Gloria has been used to, say in social situations where she cannot cope with overwhelming feelings of stress.

For me, an interesting parallel process is the idea of perfectionism. As I read back my interventions, I often wishfully think I had expressed myself more succinctly so that I would hear a more ‘perfect’ response. This push or desire for the perfect response or intervention could in turn develop into a fear of being in the counselling situation because of the client’s reaction to my interventions. At the same time, as an extension of these considerations of wishes and expressions, there might be a desire for the client to provide the perfect answer for the counselling psychologist. And in addition to this, I wonder how any pressure of wanting to be the perfect psychologist for the client or Gloria wanting to be a perfect client for me might have affected this session.

As a trainee, I know that I experienced an acute level of performance anxiety in producing this process report – wondering how the examiner would consider me and maybe view me as deficient in some way as a counselling psychologist in training. I would love to assert that my practice has meant a greatly reduced level of anxiety in this aspect, which would not be true, although I can acknowledge that experience has reduced this anxiety and I rely more on theory, guidance and feedback from the client to ensure I carry out my practice to the best of my abilities.

With regards to the client's need to provide perfect answers or be the perfect client appears to be much simpler to cope with in practice: reassurance that there is no perfect answer or solution as well as the core principles of counselling (empathy, unconditional positive regard and congruence) help the client to be assured that they can come as they are and explore what it feels like not to require themselves to be perfect in the counselling session.

And through experience as well as transposing these principles to myself as psychologist, albeit requiring myself to practice professionally at all times, I can see that I come as I am into the counselling room and am only able to offer who I am in the most congruent, empathic and unconditional way to myself. And maybe through this acceptance of who I am as a trainee, I can myself break down defence mechanisms, as Gloria did in this process report, in order to experience myself as I am and not who I think I should be.

C9 Ethics

Gloria signed a consent form confirming agreement to having her sessions recorded. She understood that any session may be used for the purpose of writing a report as part of my training and that any marker or external examiner would treat the recording and report in confidence.

Section C References

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Section C Appendix A – Case Formulation

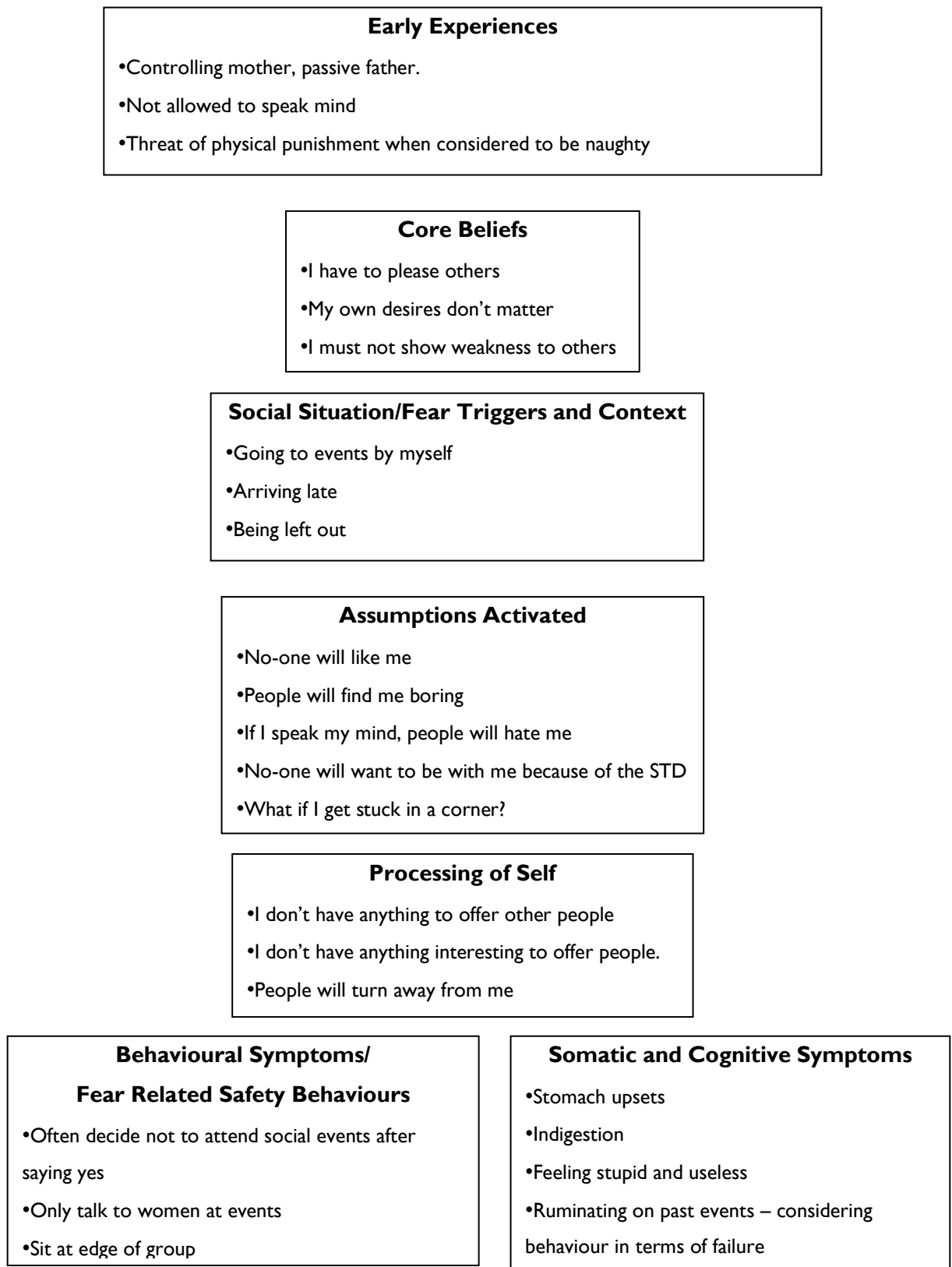


Figure 9 Case Formulation