



My Invisible PTSD: Exploring the Experiences of Recovery in Treatment Seeking Veterans

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Abstract

Research suggests that exposure to multiple traumas increases the risk of some individuals developing post-traumatic stress disorder (PTSD). Military service can expose individuals to multiple traumas and therefore ex-military personnel are at high risk of developing mental health disorders and PTSD. Additionally, veterans have been found to underuse mental health services. Research has used quantitative methods focused on barriers to accessing services, with less emphasis on factors that enable veterans to seek support. The aim of this qualitative research study was to explore the experiences of veterans who seek treatment and how they define their experience of recovery. A non-random sample of nine male veterans participated in semi-structured interviews. Participants had all completed a residential six-week Intensive Treatment Programme at Combat Stress, were in the same cohort, and all had diagnoses of PTSD. Qualitative data was collected using semi-structured interviews and was analysed using Interpretative Phenomenological Analysis (IPA) to extract common themes from the interviews. Four key themes emerged: (1) discovering PTSD: breaking the silence, experiences of diagnosis and normalisation and containment; (2) engaging with PTSD: preconceptions and the challenges of military identity and accepting PTSD; (3) a road to recovery: a shared experience of PTSD, finding me again and adjusting to civvy street; and (4) maintaining and rebuilding: owning your PTSD, tackling PTSD in everyday life and managing social relationships. Social support systems from both cohort peers and family were highlighted to be as important as clinical treatments themselves. Services should continue to encourage veterans to overcome social avoidance, to create strong peer groups, and to involve the wider family within treatment programs.

Keywords: Military, mental health, PTSD, recovery

Introduction

Approximately 15,000 individuals leave the United Kingdom (UK) military each year (UK Ministry of Defence, 2019; Defence Analytical Services Agency, 2017; Murphy et al., 2019). Although the majority of UK veterans transition into civilian life with no problems, there are a significant minority that leave with or go on to develop mental health difficulties (Iversen et al., 2011). Large-scale cohort research has investigated the prevalence of mental health outcomes in UK personnel from 2003 onwards (e.g. Fear et al, 2010). In the most recent iteration of this study, it was found that the rate of common mental disorders such as anxiety and depression in veterans was around 20% and the prevalence of post-traumatic stress disorder (PTSD) was reported to be 9.4% in deployed veterans (Stevellink et al., 2018). Evidence shows that PTSD is frequently experienced alongside other difficulties with individuals meeting case criteria for another primary health outcome such as alcohol misuse (42.7%) (Murphy, Ashwick, Palmer, & Busuttil, 2017).

Despite the high prevalence of mental health disorders within this population, research has found that veterans underuse mental health services. A large cohort study found that only 31% of veterans who experience recent mental health problems sought help and accessed treatment (King's Centre for Military Health Research, 2018). The UK armed forces are not the only population that struggles with help seeking for mental health problems. This stems across society and within the US, Canadian, and Australian militaries (King's Centre for Military Health Research, 2018). Given the large number of veterans who struggle with seeking help, research to date has focused on

understanding the barriers or facilitators to accessing treatment (Murphy, Hunt, Luzon & Greenberg, 2013).

Research suggests that a common barrier to seeking treatment is stigma (Iversen et al., 2011). Additionally, self-stigmatising beliefs are a common barrier for veterans who report not seeking help, as doing so would cause them to feel weak (Sharpe et al., 2015). The role of stigmatizing beliefs in help-seeking has largely been investigated quantitatively, finding a strong, negative relationship between self-stigma and help-seeking in the veteran population (Coleman, Stevelink, Hatch, Denny, & Greenberg, 2017; Murphy, Palmer & Busuttill, 2016).

There is a paucity of research investigating the factors that enable veterans to seek help. However, studies suggest that some factors that compel veterans to seek treatment include: family and friends, psychoeducation, severity of symptoms, and level of distress (Sayer et al., 2009; Pilkington, Msetfi & Watson, 2011; Kim, Britt, Klocko, Riviere, & Adler, 2011). Yet research is sparse into the experiences of these veterans who do access treatment for PTSD and what their lives are like beyond treatment; do they experience recovery and, if so, what supports this process or makes it more challenging? (Iversen et al., 2009).

Young and Ensing (1999) defined recovery as an individual's unique journey to overcoming "stuckness," improving their quality of life, and re-defining themselves following distress. This research also highlights the importance of spirituality and supportive relationships when seeking help for mental health difficulties, along with a return to basic functioning (e.g., taking care of oneself, eating) as symbolic of being "recovered" (Young & Ensing, 1999).

In comparison, some researchers link recovery with post-traumatic growth (PTG), which has been described as the positive changes that some people experience following exposure to traumatic events, such as enhanced personal strength or spiritual change (Tedeschi & Calhoun, 2004). Research suggests that there is a relationship between improvements in symptoms of PTSD and depression with regard to higher levels of PTG (Murphy et al., 2016). Brewin, Garnett, and Andrews (2011) undertook a mixed-methods analysis of veteran's views on their lives post-treatment; they found themes that link with the idea of PTG such as enhanced relationships. However, the study is limited, as the aim was not for thorough exploration of veterans' recovery experiences, thus factors which may have brought about change were not studied.

Further research is needed into the actual experiences of veterans who seek treatment and how they define their experience of recovery. The present study aims to qualitatively investigate three main questions: how do veterans make sense of their lives following a diagnosis of PTSD? What factors facilitated their pathway to recovery? And what challenges have they experienced during their process of recovery?

Methods

The qualitative methodology Interpretive Phenomenological Analysis (IPA) developed by Smith (1996; Smith & Osborn, 2008), was used to meet the research aims. Instead of uncovering an objective reality, IPA seeks to capture the experience of individuals as they have constructed it. Thus, in IPA, it would not be assumed that constructs such as "recovery" or "PTSD" would hold the same meaning for different people. IPA, with its focus on phenomenology and the study of "being," is consistent with the research aims of understanding the realized experience of living and recovering from a diagnosis of PTSD from the viewpoint of veterans themselves. Although previous research has explored people's experiences of trauma (e.g. Lawrence & Lee 2013), to the best of our knowledge, there is a limited amount of studies specifically exploring how veterans make sense of being diagnosed with PTSD and their pathways to recovery using IPA.

Setting

All participants were recruited from the charity Combat Stress (CS). CS is a national charity in the UK that provides mental health services to veterans (combatstress.org.uk). Recruitment from CS enabled the researcher to engage participants who had all served in the armed forces, received residential treatment for PTSD, and therefore had the relevant lived expertise for the research aims. CS offers a comprehensive six-week treatment course for veterans who have been diagnosed with PTSD, which includes psychoeducation and skills training (e.g. mindfulness, cognitive-behavioural therapy techniques), as well as individual trauma-focused psychological therapy and groups (combatstress.org.uk/get-help/how-we-help/treatment-programmes).

Participants

In total nine veterans who had completed the six-week treatment course participated in qualitative interviews. This sample size is consistent with the chosen IPA methodology which typically involves three to 15 participants (Smith, Flowers, & Larkin, (2009). Data collection concluded when themes within the interviews became saturated (Smith, Flowers, & Larkin, (2009). Participants were recruited towards the end of their six-week intensive treatment program at CS. The researcher (PH) then contacted participants two to three months after recruitment to request to be interviewed.

Inclusion and exclusion criteria

The inclusion criterion for this study was partially determined by the inclusion and exclusion criteria for the CS treatment programme. Therefore, participants must have been exposed to two or more traumatic experiences (one of which must be related to military service), have a diagnosis of PTSD, and have served in the armed forces for at least one day. To access this treatment program, veterans must not be diagnosed with a personality disorder, not be currently dependent on alcohol, exhibiting symptoms of psychosis, feeling suicidal, or have a suspected traumatic brain injury.

Data collection

As outlined earlier, there is a paucity of research into the lived experience of veterans who have been diagnosed with PTSD and how they make sense of their diagnosis and lives following treatment. Qualitative research within this area would allow for the personal and social experiences of the individuals to be explored, described, and interpreted (Smith, 2008). IPA was used to analyse transcript data from interviews as outlined by Smith et al. (2009) and Larkin and Thompson (2012). Guidelines for quality in qualitative research (Elliot, Fischer & Rennie, 1999) also informed this procedure, including the importance of reflexivity, striving to create a coherent and plausible narrative, and drawing on peer and professional supervision.

All interviews were administered over the telephone by the researcher (PH), due to the practicalities of participants living all over the UK. A review comparing research into the validity of telephone versus face to face interviews found few differences in consistency and quality of data between these modes (Bowling, 2005).

Interviews were undertaken on speakerphone and recorded on a digital voice recorder. Interviews began by the researcher going through the informed consent process and recording this in a separate audio file to maintain participant confidentiality. Secondly, the researcher reminded participants of confidentiality, that they could withdraw or take breaks at any point, and that they were welcome to ask questions.

The main interview used a semi-structured interview and lasted between 45 and 70 minutes depending on participant's engagement with questions. Five questions were asked regarding participants experiences of recovery:

- (1) When did you first receive your diagnosis of PTSD?
- (2) At the time, did you feel this diagnosis fitted your experience?

- (3) What does “recovery” mean for you?
- (4) How might you describe recovery in terms of your diagnosis of PTSD?
- (5) If you compare your life now, to how it was when you were last diagnosed with PTSD, do you notice any change? Prompts were used like: How about now? Why? And in what way?

To increase reflexivity, following each interview the researcher recorded reflections and thoughts that came to mind during the interview. The interviews were typed into a transcript for analysis by the researcher.

Data analysis

Firstly, the researcher became familiar with the transcripts and made running commentary notes. These included notes on what appeared to matter to participants, including their claims, concerns, or any understanding of treatment or recovery. The researcher then used these notations to look for repeating themes which emerged from surface text. Sub-themes were then labelled. The next phase utilized a more analytic approach as the researcher strived to make sense of connections between themes (noting commonalities and differences) and clustering them together. The theme clusters were given a descriptive label aiming to capture the meaning from the text and formed the superordinate themes. This process was iterative as the researcher repeatedly checked their interpretations and themes with the original text. A table of superordinate and subordinate themes and corresponding quotations from transcripts was produced.

Ethics

Ethical approval was sought and granted from the University of East London and CS independent research committee consented for the researcher to recruit from their treatment centre.

Results

A summary of the demographic data that was collected from each of the nine participants is provided in Table 1 (see appendix). A summary of the superordinate and sub-themes that emerged from the text are provided in table 2. Below each of the themes is further explored.

TABLE 2. SUMMARY OF SUPER-ORDINATE AND SUB THEMES

Super-ordinate Theme	Sub Theme
<i>Discovering PTSD</i>	Breaking the silence Experiences of diagnosis Normalisation & containment
<i>A road to recovery</i>	A shared experience of PTSD Finding me again Adjusting to civvy street
<i>Engaging with PTSD</i>	Preconceptions and the challenges of military identity Accepting PTSD
<i>Maintaining & rebuilding</i>	Owning your PTSD Tackling PTSD in everyday life Managing social relationships

Discovering PTSD

Breaking the silence

A sense of shame in seeking help filtered through many participants' narratives. Five veterans explicitly named fear of losing relationships or "hitting rock bottom" in a "shit storm" of emotions, which in two instances led to attempts to take their own lives, as motives for over-coming their prejudices and finally seeking help. "I was quite ashamed to sort of let people down, so I just didn't get the help." (Participant 4)

Participant 1 explained he suffered in silence because he wanted to protect his loved ones from his horrific experiences and not let them down by admitting "weakness," by showing he had been emotionally affected by his experiences. "Talking about it is the initial ... massive thing to do—it's not the answer... 100%, but until you do that... you can, that there is somebody there who will listen and once you realize that, you are on the road to recovery." (Participant 1)

The relief of opening up and telling someone about their difficulties was identified by some participants as a key moment in their treatment journey: Participant 1 pinpointed talking as a key moment in alleviating some of his sadness and freeing himself from the burden of his memories which he bore alone. "I'm... nowhere near as sad as I was. I can talk about the problem." (Participant 1)

Experiences of diagnosis

All but one participant suggested diagnosis was important for finding a much-needed understanding of their difficulties. Veterans described gathering their own understanding of PTSD at different points from diagnosis to treatment. The support from a professional who appeared knowledgeable and to understand them was identified by most participants as being key to this process: "To have somebody with letters after their name saying the reason that you've done this and been like this is because of this, it's kind of a nice." (Participant 7)

"It made me understand why I was ... apathetic about things, getting angry about things, why I wasn't bothering to get up in the morning." (Participant 3)

For seven of the nine participants, a diagnosis of PTSD almost immediately appeared to be received as a helpful framework to understand their difficulties in their mood and relationships. "It did just make me stop and think, yeah that's me all over, all the things that they were asking me about, when I gave him the answers and they were ticking them off as signs of PTSD.... And it's all sort of fitted together." (Participant 1)

For one participant, making sense of his problems with a diagnosis of PTSD was a more complex path, in which support to make sense of the diagnosis was especially important: "Three or four psychologists have ... poured doubt on my diagnosis on several occasions because I didn't have any flashbacks." (Participant 9)

Normalization and containment

Receiving the diagnosis appeared to offer many participants a feeling of reassurance that they were "not going mad." "The biggest thing was knowing about the diagnosis, knowing the reason for why I was like I was, were completely normal given the situation. And it wasn't me going 'round the bend." (Participant 1)

A diagnosis of PTSD appeared to give participants an understanding that their difficulties were rooted in their military career or trauma exposure, not the result of an uncontrollable madness or personality change, which had felt embarrassing and terrifying. "I always thought it was just people being weak...until I was shown that it isn't, because now, I know, I know it's pretty normal." (Participant 1)

One participant, by realizing "it wasn't me," framed the diagnosis as something separate to himself, which he can perhaps purge or at the least exert some control over, offering hope that they

could change. The diagnosis of PTSD also appeared to normalize people's experiences, as it gave them an explanation of what had caused their problems and realizing they were not suffering alone.

One of the participants appeared most uneasy with having a PTSD diagnosis, which they felt left them "branded." By emphasizing that PTSD is a "physical thing" too, and reconstructing PTSD as not purely a mental health condition may make it more socially acceptable. However, the "physical" symptoms of night sweats and heart palpitations were some of the most troubling symptoms and probably exacerbating distress: "I was really worried there was something physically wrong with me, like night sweats... and when I found out they were because I perhaps dreaming or thinking about the issue, it made me feel a whole lot better, immediately knowing it was something normal, really, I wasn't weird." (Participant 1)

Engaging with PTSD

From receiving their diagnosis and throughout their treatment program, participants reported how they continued to make sense of their difficulties through learning more about the diagnosis.

Preconceptions and the challenges of military identity

Four participants explicitly spoke about the military's long and complex relationship with mental health. Historical associations of shellshock being linked to cowardice, weakness of the mind and shirking duty appeared to influence veterans in making sense of the diagnosis. "Cowardice in face of the enemy, you know — once a soldier, always a soldier." (Participant 5)

Participant 4 constructs the work of a soldier to "always" be task driven and focused, prioritising their duty whatever the potential dangers. Participant 9 discussed how diagnosis could serve to shatter people's perception of themselves as strong, which may make adjusting and accepting the diagnosis more challenging. "Even though everything fits, it's difficult to believe you personally have PTSD, you feel you are stronger than that and you shouldn't have it." (Participant 9)

Participants shared how humor and the "light-hearted military way" was an effective method of preventing discussions, which may lead to expressions of vulnerability. "I don't remember anyone ever speaking about mental health...I vaguely remember some lad saying he couldn't go because he had PTSD and we sort of took the mickey out of him, not to his face, but when we were in the mess we would say 'oh he's a coward' and all that sort of thing." (Participant 4)

Accepting PTSD

In many accounts, acceptance was cited as an important first step to coping. Most participants spoke of how having an open attitude to treatment and listening to what others suggested was key in their recovery; "You have to surrender and go with it at Combat Stress." (Participant 7)

The use of the word "surrender," which is an action of great humiliation in combat, demonstrates how difficult it felt to acknowledge difficulties and accept help.

Participant 5 compares his PTSD as being in some way similar to that of being physically injured in combat, suggesting both carry shame. "He looked at me and said, "I don't know how you get up every morning." I said, "what do you mean?" He said, "I can see my injuries, but you can't see you yours and that's soul destroying," and I said, "it is in a way, cos you're fighting another battle." (Participant 5).

A road to recovery

Interviewees reflected on the journey of recovery, a changing relationship with themselves and others from the military, and how this impacted on their transition to civilian life.

A shared experience of PTSD

All participants spoke positively about meeting other veterans who had been through similar experiences, which appeared to reduce the stigma associated with PTSD and provide a valuable support network. "They're just like carbon copies of yourself." (Participant 2)

Even for Participant 9, who in some ways had not felt the diagnosis fitted for him, appeared to find the similarities he had with other veterans outweighed these differences: “They are still having the same sort of problems makes somehow my problems more manageable or more understandable.” (Participant 9)

Meeting others gave people hope they might overcome difficulties, but also a sense of familiarity through discovering shared personality characteristics and values (e.g. black humour, practical approach to life), as some had felt lacking in their civilian contexts. “That sort of team spirit, you know umm... being ex-army.” (Participant 8)

Feeling part of a group with shared experiences appeared important for many participants, as they shared experiences of feeling isolated prior to treatment. Even those with friends and family had struggled to talk about their problems, and it appeared meeting other veterans ultimately supported the process of talking about their difficulties.

Participants engaging with other veterans appeared to be a steppingstone to being increasingly sociable once they returned home, after feeling cut off from others or self-imposed isolation for many years. This sense of connection and mutual support had extended beyond treatment to this interview, with all participants reflecting on the friendships they had made at CS with other veterans: “It's a text here or there, or a call when someone's feeling down from my side or their side, you know. Umm, that's been really good, I made some close friends there.” (Participant 8) Like Participant 8, four other interviewees explicitly spoke of how helping and supporting others positively supported them in their recovery.

Finding me again

Completing treatment and returning home prompted self-reflection in many participants about their identity. Some participants described how treatment had made them aware of how much their personality had changed over the years, which for Participant 5 was a shock. “I had to walk out as it made me physically sick, realizing that I had been like that for such a long time and actually thinking Jesus Christ, what the hell? Where have I been? What has been going on?” (Participant 5)

“Sometimes I'll do something and go ‘right well that was PTSD. Ok, let's cut that out.’ It's actually, it's not an excuse, but it's a...identification if that makes sense, that I'm doing certain things because, part of [my] brain is doing this and that's really helping.” (Participant 6) Both participants share an enhanced awareness of the self, but also a sense of power to make changes in how they act, behave, feel, and appear in the world.

Additionally, participants discussed the gains made from therapy leading to an increased sense of self. This is mentioned in terms of personal development as well as identifying returning to previous versions of themselves. “I think I'm more positive and confident in myself umm... there's still a little bit of a challenge, I'm still not the most sociable of people...do feel the old Tom coming back.” (Participant 7)

Adjusting to civvy street

Veterans reported struggling to find a role in civilian life and accessing the appropriate support. This is likely to have further alienated some of these veterans from others and isolated them in their difficulties. “This is my civilian life basic training.” (Participant 5)

“The [General Practitioner] referred me to the community mental health scheme and umm... they were really unhelpful [...] Because I wasn't in the best place at the time, I got relatively frustrated with it and in the end just turned around and said I'm really sorry I can't talk to you.” (Participant 6)

After treatment, integrating into civilian life and finding meaningful work or a role was still challenging for some participants and caused them continued distress. Several veterans described how difficult it was to adjust to a loss of status from no longer working, along with a sense of anger at

their opportunity to work being stolen from them by PTSD. “I’m not going to work again. Now that took a lot of accepting by me...because of the amount of insomnia I’ve got, the fatigue that I’ve got, and to a certain extent my age.” (Participant 9)

Some participants spoke about previously cutting ties with former colleagues and avoiding anything to do with the military. “I couldn’t get away quick enough [...] I never spoke to anyone in the army, never spoke to any of my friends.” (Participant 4)

For most veterans an effective survival strategy was creating distance away from anything associated with the military, which had caused them significant pain.

Maintaining and rebuilding

All but one of the participants regarded recovery as a life-long process. Most participants took an active approach and stated it was down to them to continue what they had learned during treatment.

Owning your PTSD

Five participants had noticed that learning coping strategies had enabled them to exert more control over their emotions and own their PTSD. “I mean you’re recovering all your life, cause there’s always going to be a knock back. But it is accepting it is a knock back and getting over it... and carrying on. It’s not a hurdle, it’s a little gate and I’ll open it and go right through.” (Participant 1)

Many interviewees recognized difficult days would still lie ahead but reflected since treatment they had more confidence in their ability to cope. “I don’t think my PTSD has got any better, but I know what to expect from it.” (Participant 9)

Participant 6 advocated a normalised perspective that everybody faces challenges in their “quality of life”: “I like the idea of it being kind of...yeah you know, you’ve been through that it’s fixed, let’s move on you know. So yeah, if I was going to say anything... even though it is probably on-going, I think everyone’s quality of life is on-going in one way another.” (Participant 6)

Nearly all participants recalled at least one of these different strategies as helpful during interviews. “I quite enjoy the mindfulness...I try to do that when I walk my dogs, you know about mindful walking...and also a yoga group...I found that very relaxing... because your mind racing all the time with PTSD.” (Participant 2)

Tackling PTSD in everyday life

All participants spoke of PTSD as being something which to a certain extent had to be tackled alone, which required significant personal motivation in everyday life. “I’m quite a practical person and I know if there’s something wrong in my engine in my car, I’ll take it to a garage, and they’ll fix it. And that’s how I tried to think about this is that... OK you’re a bit broken, this is what’s wrong with you, let’s get it fixed.” (Participant 7)

Participant 2 described still experiencing difficulties in his mood and a disconnection from others aside from veterans: “It is difficult because I have good days and I have bad days, I have days when nothing goes right, or nothing feels like it goes right...you’re cross and angry at everyone all the time...” (Participant 2)

Participant 6 described similar experiences; “Some days I feel completely in control...and I’m doing really well, and things are great, and you know nothing can touch me. I still have low days. You know as everybody does.”

Managing social relationships and PTSD

All participants reflected on how support from family, friends, and colleagues impacted upon how they felt about themselves and their diagnosis of PTSD. “Lots of support from family. It’s all brilliant and I want to repay them by not being such an arse.” (Participant 1)

Participants with long-term partners stated that their partners had encouraged them in seeking help and supported them since leaving treatment which they had found valuable. Three participants also expressed some admiration that their partners had stuck with them through all their difficulties. “I mean Lucy [partner] would have been well within her rights...she could have cut me loose... it doesn’t bare thinking about.” (Participant 4)

Participant 4 reflected on what PTSD had cost him, but also suggested a motivating factor for seeking help and staying on a recovery pathway was wanting a relationship in the future: “I think I lost a lot. I lost a beautiful house, life, a wonderful partner and all that I lost, and I think the...you know that, I think that may have been a good incentive, unless you deal with this, you’ll never have anything again.” (Participant 7)

Participants also spoke of how they had felt empowered to share some of their difficult experiences with family, which helped alleviate feelings of isolation: “It’s changed our relationship immensely, erm but it has changed because they understand what’s going on.” (Participant 3)

Gaining a sense of feeling understood by partners and family was supported by their attendance at a “significant other day,” which was part of the veteran’s treatment at CS. Two participants who were single and invited other family members, also cited this day as an important component of their recovery process. It appeared giving the participants’ significant others psychoeducation about what they had been going through increased their understanding and better equipped them for continuing to support veterans once they were home. “She’s got a bit more of a tolerance for my ‘bits’ shall we say, whereas beforehand it was, ‘for god’s sake, snap out of it; sort yourself out’ [break] instead of being pissed off that I’m down, that subtle change of accepting and acknowledging it.” (Participant 6)

Discussion

Main findings

This study explored how veterans make sense of their lives following a diagnosis of PTSD, what facilitates their pathway to recovery, and the challenges they experienced during their recovery process.

In general the veterans reported a reduction in external stigma, self-stigmatizing beliefs, and shame after accessing services, compared with their experiences towards their mental health within a military setting. Most veterans gave value to meeting other veterans with similar challenges and sharing these experiences during their treatment at CS; all of which contributed towards reducing their internalized stigmatizing beliefs. Veterans also highlighted how recovery is a continuous and multifunctional journey, involving biological, social, and psychological aspects.

We identified four superordinate themes related to veterans’ experiences with recovery: discovering PTSD, engaging with PTSD, a road to recovery, and maintaining and rebuilding.

Superordinate theme one: Discovering PTSD

This initial theme refers to the unearthing of their mental health symptoms, which generally speaking, was achieved through taking the step and opening up about their challenges and receiving a diagnosis of PTSD. Participants expressed feeling a strong sense of shame about their PTSD symptoms and worry about the effect it would have on their families, which had contributed to not admitting they needed help until they were at breaking point and no longer able to cope. Thus, a significant aspect of recovery was the initial step of admitting (to themselves and others) there has been a detrimental change in their mental health, which has impacted their daily activities and family life. Previous research has found a similar pattern of veterans reaching a “crisis point” until they reach out for mental health support (Murphy et al., 2013). Even though one participant experienced difficulties receiving a diagnosis of PTSD, all appeared to benefit from a diagnosis of PTSD, as a

label acted as an explanation of their difficulties, which ultimately led to normalising and containment.

Superordinate theme two: Engaging with PTSD

This theme encompasses the veteran's perceptions of military identity and how experiencing mental health difficulties can challenge these engrained beliefs and values. Participants expressed that being a soldier means always being focused and on task and not showing any weaknesses both physically and mentally. One of the first steps in the recovery process as challenging such beliefs can shatter veteran's self-perception of being strong. Many participants spoke about how an important second step was accepting their PTSD, which enabled an open-minded attitude to treatment. This was an important transitional that continued for a period after receiving a diagnosis and throughout their treatment. Being able to accept and make sense of why they had felt and behaved in certain ways in the past was a critical phase for reducing self-blame and forgiving themselves. Learning and accepting that PTSD is a lifelong journey was another vital step towards adopting positive change in their lives. Increased confidence with their ability to cope could potentially be linked to participants reporting less avoidance type behaviours and higher engagement with positive self-care.

Superordinate theme three: A road to recovery

For this theme participants described how meeting veterans with similar mental health difficulties as part of their treatment, provided a support network for when they had finished their intensive treatment program at CS, somewhere it would be useful to include what modalities are included in the care at CS (e.g., talk therapy, Cognitive Behavioural Therapy, Prolonged Exposure Therapy, Eye Movement Desensitization Reprocessing, group and individual therapy). Meeting other veterans also gave others hope and motivation towards positive change for their future, which can be a powerful motivator in recovery. Avoidance is an element of PTSD pathology and therefore the social aspect of being treated within a cohort, instead of feeling isolated and avoidant of social contact, was a helpful part of the road of recovery; veterans had to face up to these unhelpful coping strategies (e.g. emotional avoidance) and behaviours (e.g., social avoidance). Additionally, being part of a cohort as part of treatment was familiar to the veterans as the structure mimics that of a military environment.

Veterans also expressed that the recovery journey continues even after treatment, the transition from being a service member to a civilian required self-reflection into participants' identities. Some participants mentioned wanting to be a new version of themselves and others expressed wanting to return to a previous version of themselves before PTSD. As cognitive flexibility has been found to positively correlate with PTG and optimistic expectations for the future (Keith, Velezmore & O'Brien, 2015), this more flexible thinking and insight could perhaps improve the timeliness of the recovery journey for veterans.

Superordinate theme four: Maintaining and rebuilding

A common theme for most participants was that they now regarded recovery as a life-long process in which participants took an active approach and felt empowered to continue to develop in all aspects of their lives. Additionally, during this phase of the recovery journey, participants reported they knew what to expect from PTSD, including setbacks and relapses and accepted that this might happen during the transitioning into civilian life. The realisation that adopting positive coping strategies and embedding these within all aspects of their lives, such as maintaining social relationships, enabled them to exert and feel in control of their emotions. This gave an overall realisation that they were taking ownership of their PTSD. The role that caregivers seemed to play was predominantly that of a pillar of strength and support throughout the recovery journey. In this stage, veterans showed more reflections and insight to how their PTSD had impacted family life and how they wanted to show their gratitude for their support. Furthermore, involving partners in

veterans' treatment has been shown to improve the severity of veterans' PTSD symptoms (Monson et al., 2012) again highlighting the importance of social support in recovery.

Strengths and limitations

Although this study provided an important and up to date insight into veterans' experiences of recovery, it is not without its limitations. One limitation was that the sample consisted of male participants who were all British and Caucasian. Additionally, the veterans were recruited from the same cohort who were receiving the same treatment from CS. Taken together, the methods of sampling could have minimised the generalisability of the results to be representative of the wider veteran population. On the other hand, in spite these limitations, this study highlights the importance of treatment and of psychological input for veterans with PTSD. Although often most help-seeking veterans are male perhaps due to the veteran population mostly being male, additional studies could explore experiences of recovery in minority veteran groups (e.g. females). Due to the methodology and the teams understanding of the veteran population, this research provides meaningful and personal concepts into what influences recovery. As discussed previously, the veteran population are a challenging group to engage with research studies and with clinical work; this can partly be accounted for by the negative attitudes to help seeking and masculinity. This is especially true as the veteran population are at risk of cumulative trauma exposures (Landes, Garovoy & Burkman, 2013) furthermore, a high percentage of veterans are exposed to multiple traumas, either as a child or in a combat role in the military (Murphy et al., 2017).

Clinical implications

Clinically speaking, it is important to examine if there are trends in recovery that are generalizable to the wider population for the development of mental health services, especially due to the current climate of meeting the expectations of funding bodies. This research suggests that veteran's recovery journey continues post intensive treatment programmes. This element of recovery seems a powerful part of self-discovery, learning how to function successfully into civilian life. Thus highlighting the importance of cognitive flexibility to be used both in and out of the therapy room, this is in keeping with research into the value of cognitive restructuring for PTSD (e.g. Power et al., 2002). Due to the weight participants put on peer support and group therapy, treatment programmes should mirror the structure of military settings as much as possible. Realistic expectations of PTSD were also highlighted as a key part of recovery, which is useful knowledge for the professionals to consider during the early stages of treatment.

Conclusions

This study highlights the importance of psychoeducation and group-based treatment for UK veterans with PTSD. In addition, the experience of being treated within a cohort provides a familiar framework like that of a military setting, which had a positive therapeutic effect in their recovery journey, alongside normalizing mental health experiences. At the same time, participants expressed that family support was an additional facilitating factor to aid the recovery process. It is important to note that the recovery process continues long after treatment has commenced as veterans' transition into the civilian way of living. Taken together, this research suggests working systemically and involving families in the treatment journey would be beneficial for the veteran.

Overall, social support systems were highlighted to be as important as clinical treatments for this group of ex-military personnel. Services should continue to encourage veterans to overcome social avoidance, to create strong peer groups, and to involve the wider family within treatment programmes.

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Appendix

Table 1. Demographic Data

Participant	Name	Age	Relationship Status	Employed	Previous Service	Rank	Years in Military	Year left
1	John	40-49	Married	Yes	Army	Ranks	23	2010
2	Dave	30-39	Partner	Yes	Army	Ranks	5	1997
3	Simon	50-59	Widower	No	Navy	Ranks	19	Missing
4	Mark	40-49	Partner	Yes	Army	Ranks	20	2005
5	Craig	30-39	Single	No	Army	Ranks	14	2012
6	James	30-39	Married	Yes	Marines	Ranks	11	2014
7	Tom	40-49	Single	No	Army	Ranks	3	2013
8	Nick	30-39	Single	Yes	Army	Ranks	4	2005
9	Bill	60-69	Married	Retired	Airforce	Officer	40	2013

Note: Pseudonyms were used to maintain anonymity of participants identity