Stepping out of line: Constructions of Trauma in the UK Military

by

Jane Gilbert

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Faculty of Arts and Human Sciences
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Introduction to the Portfolio

This portfolio contains work completed during the Doctorate of Psychology (PsychD) clinical training course. This volume comprises three sections: academic, clinical and research.

The academic section contains the Professional Issues Essay, two problem-based learning accounts and two Personal and Professional Learning and Development Group (PPDLG) process account summaries.

The clinical section contains a summary of all five placements.

The research section contains a research log checklist, the Service Related Research Project (SRRP) completed in Year 1, an abstract of the qualitative research project completed in Year 1 and the major research project, completed in Year 3.

The work presented in this portfolio reflects the range of client groups, presenting problems and psychological approaches covered during the course. All identifying details have been changed or removed in this portfolio in order to maintain confidentiality and anonymity.

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I would like to say thank you to all those people; staff, clients, family and friends who have contributed, knowingly or otherwise to my learning, development and future career.
Academic Section
Literature Review:

What is the status of a diagnosis of Complex Posttraumatic Stress Disorder (CPTSD) and what is the evidence for the effectiveness of interventions with adults who have CPTSD-symptoms?
Abstract

The concept of Complex Posttraumatic Stress Disorder (CPTSD) (Courtois & Ford, 2009) or Disorder of Extreme Stress Not Otherwise Specified (DESNOS) is one that has attracted debate and controversy. Is it a separate entity from Posttraumatic Stress Disorder (PTSD), already in DSM IV? (American Psychiatric Association, 2000; Courtois, 2008; Ford, Courtois, Steele, van der Hart & Nijenhuis, 2005; Korn & Leeds, 2002;). Perhaps as a result of this diagnostic difficulty, attempts to establish effective treatment approaches have been scant. This is surprising considering the amount of people with CPTSD-symptoms within psychiatric populations (Courtois, 2008). A consensus of research suggests that CPTSD exists as a separate diagnostic entity to PTSD and that treatment is best attempted through a transtheoretical approach which uses empirically-supported protocol-based treatments within the wider context of a three-phase meta-model. This involves a focus on the client achieving emotional self-regulation skills and a secure attachment within the therapeutic relationship before more specific trauma-focused work is attempted (Courtois, 2008; Korn & Leeds, 2002; Pearlman & Courtois, 2005; Resick, Pallavi & Griffin, 2003).

Introduction

Declaration of Interest

This topic area is of interest to me for two reasons. Firstly, in my previous clinical experience (forensic), it occurred to me that many clients who had a primary diagnosis of a personality disorder (usually antisocial or narcissistic) also had
complex histories of abuse that did not seem to be addressed in their treatment plans. I had a discussion with a patient who had been convicted of murder about what he thought of his additional diagnosis of Posttraumatic Stress Disorder. He appeared bewildered by the expectation that he would participate in therapy which he did not feel able (yet) to manage emotionally. His confusion made me think about how conceptualising trauma raises questions about diagnosis and the politics of treatment relevant for the discipline of psychology as a whole. Secondly, my Service Related Research Project (SRRP) is related to how Complex Trauma and Dissociative Spectrum Disorders are understood and treated within the Trust, and as such I wanted to gain a greater understanding of the current position on these topics.

Much of the literature in this area is theoretical and as neither CPTSD nor DESNOS are currently recognised as diagnoses within DSM IV, (American Psychiatric Association, 2000) research on treatment outcomes is scarce and the complexity of the area makes methodologically robust research difficult. This review aims to establish the status of evidence for a diagnosis of CPTSD and to evaluate what research has to say about what treatment might look like. If CPTSD is included in DSM V, as is currently under consideration, then it is likely that the National Institute of Clinical Excellence (NICE) will require treatment guidelines, and a synthesis of research into effective treatments will be vital.

Parameters of the Literature Review

The objective of this review is to examine the evidence for the diagnosis of CPTSD and evaluate treatments that address CPTSD symptoms. There is a great deal of literature on PTSD and its treatment. However, there is much less on CPTSD, which perhaps reflects its lack of current status as a diagnosis within DSM IV (American
Psychiatric Association, 2000) or ICD-10 (World Health Organisation, 2007). As a result, research into effective treatments for CPTSD is limited by the contradiction that they are evaluating treatments for something which, arguably, does not exist. In this review, both theoretically-based literature and practical research have been examined.

Due to psychology’s mandate to endorse empirically-supported treatments, much of the work around CPTSD is based on findings from research with PTSD. The necessities and challenges of this approach are discussed. However, a comprehensive assessment of treatments for PTSD is beyond the scope of this review, and treatments which have been applied to CPTSD groups have instead been selected. Research on military populations has also been excluded as there is a developing separate body of literature in this area.

As CPTSD is known by various names, these were included in the search terms for the review. These are: ‘Complex Trauma,’ ‘Complex PTSD,’ ‘Disorders of Extreme Stress Not Otherwise Specified, ‘DESNOS’, and in databases these labels were included with the terms ‘treatment’ or ‘interventions’. The databases used were PsycINFO and ISI Web of Knowledge.

Finally, a note on language: Where the term ‘patient’ has been used in the literature, I have replicated this, but in my own analysis I have chosen to use the term ‘client.’

**Trauma Diagnosis: From PTSD to CPTSD**

It has been suggested that trauma has become an area of such interest in psychology due to the amount of trauma-inducing events the world has witnessed in the last 100 years (Wilson, 1994). It seems likely, however, that this is more related to our
increased awareness of such events through mass communication systems, as well as increasing accessibility of medical care which can identify people suffering from the effects of trauma in a way that was previously impossible. This raises the issue of whether adverse reactions to trauma are increasing, or whether we are just more adept at detecting or labelling it.

The concept of trauma has been subject to alteration and reclassification throughout its history. It appeared in Freud’s work in the guise of ‘traumatic neurosis’ (Wilson, 1994) and it was this that formed the staple understanding of the subject in the medical and psychiatric profession until the end of the Vietnam War (Wilson, 1994). PTSD was first included in the third Diagnostic and Statistical Manual of Mental Disorders (DSM III) (Wilson, 1994) as a result of the need to name to the psychological stresses of war veterans returning from Vietnam. Controversy surrounded this diagnosis as something that was both event-specific and ‘inappropriately medicalised political dissent,’ (Lemboke, 1998, cited in McNally, 2003, p.230). This demonstrates the impact that the social and historical context can have on definitions and treatment within psychology, and that objective and ‘scientifically’ validated research can in fact be value-laden. In any case, the label was routinely applied to other posttraumatic syndromes such as Rape Trauma Syndrome and Child Abuse Trauma (Courtois, 2008). However, research into Dissociative Disorders and their association with childhood abuse led to the conclusion that people who had experienced chronic trauma did not necessarily have the same psychological problems as those diagnosed with PTSD (Courtois, 2008).
A New Conceptualisation of Chronic Trauma?

Problems such as depression, anxiety, dissociation, substance abuse, risk-taking behaviours and interpersonal problems were initially categorised as co-morbid with PTSD. (Courtois, 2008). Additionally, in many patients presenting for treatment, it was these features that appeared to be the most problematic (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The recognition of CPTSD or DESNOS to represent this distinctive group was proposed (Courtois 2008; Pelcovitz, Roth, Mandel, Kaplan, Resick & van der Kolk, 1997). This form of trauma has been described as something ‘that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts’ (Courtois, 2008, p.86).

Clinicians and researchers began to recognise that victims of childhood abuse had experienced a complex process rather than a series of discrete episodes which often featured severe neglect and emotional invalidation. It was hypothesised that an environment of chronic abuse or neglect was strongly predictive of the development of psychiatric symptoms and of someone becoming a psychiatric patient. Indeed, a significant amount of psychiatric patients (40-70%) have been victims of abuse (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). As much of this theory was developed based on work with survivors of childhood abuse, it could be subject to the same criticism as work on PTSD: it is population-specific, and thus its extrapolation to other populations needs to be substantiated.

It has been observed that patients who have experienced abuse and meet the criteria for PTSD also demonstrate symptoms in the cognitive, social and affective domains, resulting in problems with their sense of self, the formation and maintenance of secure relationships and in emotional regulation and impulse control (Korn & Leeds,
2002). Additionally, if trauma was chronic and occurred early in the lifespan, people are more likely to have symptoms surplus to those of PTSD. Trauma with its roots in the interpersonal domain also increases the risk of developing the ‘associated features’ of PTSD than would events such as an accident (Korn & Leeds, 2002). This evidence seems to support a distinct category for CPTSD, or at least demonstrates the need for a concept to account for experiences not accounted for by PTSD.

In DSM IV, 27 core symptoms which formed the ‘associated features’ of PTSD were isolated (Korn & Leeds, 2002). Field trials found support for seven symptom areas that did not fit PTSD criteria. These were problems with: affect and impulse control, attention or consciousness, self-perception, perception of the trauma-perpetrator, relationships, systems of meaning and somatisation (Courtois, 2008; van der Kolk et al., 2005). Although such symptom clusters could be co-morbid with PTSD (Courtois, 2008; Pelcovitz et al., 1997), it remained controversial whether CPTSD could exist independently. Later research found that a group of military veterans undergoing treatment for PTSD failed to meet the criteria for PTSD but did fit into the symptom categorisation for CPTSD. This suggests PTSD and CPTSD are co-morbid but separate, and also that there might be something particular about experiencing CPTSD that makes sufferers more likely to seek treatment (Ford, 1999). Further research that focuses on the specifics of exposure to traumatic events is required.

**Diagnostic Debate and Controversy**

Does making CPTSD a discrete diagnosis increase the labelling and pathologising of people or does it confer the positive benefit of naming distress? The DSM IV both informs and guides assessments and interventions, so are clients with CPTSD-
symptoms missing out on effective treatment? Current NICE guidelines do not mention CPTSD, and as such, clients presenting with these symptoms are likely to be categorized as having PTSD (which has extensive guidelines and evidence based treatments). As the proposed criteria for CPTSD overlap with other diagnoses such as Borderline Personality Disorder (BPD), Generalised Anxiety Disorder (GAD) and Major Depressive Disorder, it seems to cut across the current diagnostic system entirely as well as highlighting a lack of diagnostic flexibility to account for the unique symptoms and circumstances that any client might present. Although treating CPTSD according to individual client presentation might make intuitive sense, psychology’s drive to find empirical support for intervention means the debate on CPTSD is part of a battle where ‘the emergence of new knowledge is accompanied by a struggle to gain authenticity,’ (Padykula, 2010, p246).

Evidence for CPTSD as a separate diagnostic entity is further clouded by the suggestion that there is a strong relationship between trauma experienced in childhood and the subsequent development of Borderline Personality Disorder. It has been noted that BPD ‘perhaps more than any other diagnosis, has been viewed as a posttraumatic personality and relational adaptation to childhood abuse and neglect including disruptions of attachment and bonding’ (Korn & Leeds, 2002, p. 1466). Whilst this does make the question of diagnosis more complicated, it suggests that, due to the proportion of psychiatric patients suffering from BPD, research into effective treatments for CPTSD-symptoms is much needed and could be far-reaching. It seems there is evidence for CPTSD as a separate disorder and that recognising it would facilitate further research in this area, offer recognition for distressed clients and allow the development of treatment packages. However, these
endeavours appear hampered by the complexity of client presentations, and the nature of how diagnosis and treatment develop within psychology. At the current time it is unclear whether CPTSD/DESNOS will be included in some form in DSM V (American Psychiatric Association, 2010).

Treatment

As there is still debate surrounding whether CPTSD is a legitimate category, it is perhaps not surprising there have not been any definitive answers about the best way to treat it. That said, much progress has been made in terms of what treatment might look like and the form it might take (Courtois, 2008; Courtois & Ford, 2009; Ford et al., 2005). Many researchers appear to agree that the best way to approach treatment of CPTSD is in a way that is 'phase-oriented, multimodal and skill-focused' (Courtois, 2008; Korn & Leeds, 2002). For the purposes of evaluating treatment, it will be assumed that CPTSD can be considered a separate category.

There are two major problems with evaluating treatment efficacy for CPTSD. Firstly, there has of course been relatively little research in this area. The second problem is that PTSD research (which forms the basis of much CPTSD research) was based on specific populations: war veterans, survivors of serious car accidents, and rape victims (Ford et al., 2005) and thus its applicability is questionable. However, the CPTSD debate demonstrates that, although there is overlap between PTSD and CPTSD, as they involve different symptoms it does not necessarily follow that what an effective treatment for PTSD will work for Complex PTSD.

There appear to be two viewpoints around research into treating CPTSD (Courtois & Ford, 2009; Kilpatrick, 2005). The first advocates empirical research as legitimising
treatment approaches. If an evidence-based intervention is available for a particular disorder, then it should be privileged in clinical practice. Therefore, as there is a lot of research on treating PTSD, these treatments should be used in the absence of anything better. This allows the standardisation of client experience, and the promotion of a knowledge base from which conclusions about what does and doesn’t work can be drawn (Kilpatrick, 2005).

The second position is that research into CPTSD treatment is flawed and therefore not much use in reality (Kilpatrick, 2005). As funding for treatments can usually only be secured if there is an evidence base for their efficacy, and most evidence-based treatments focus on PTSD, it is these treatments that are given more weight at the expense of more under-researched approaches. This paints a false picture of what might actually be effective (Kilpatrick, 2005). This is a circular problem because whilst CPTSD resists comprehensive empirical research, it is difficult to see how progress can be made on the basis of anything else. In terms of this review it means that much CPTSD treatment literature is theory-based and the field would benefit from more empirical research.

Treatments based on PTSD

Extensive research has been conducted into effective treatments for PTSD. Given that CPTSD overlaps with PTSD it makes sense to consider it. PTSD interventions generally involve behavioural approaches such as Systematic Desensitisation and Exposure, and cognitive approaches that focus on the meaning the individual ascribes to the trauma (Roth & Fonagy, 2005). These approaches, together with techniques such as Eye Movement Desensitising and Reprocessing (EMDR), impact significantly on self-reported PTSD symptoms and are most effective in combination.
with drugs such as Selective Serotonin Reuptake Inhibitors (SSRIs) (Roth & Fonagy, 2005). There is limited evidence for the efficacy of psychodynamic approaches (although this could be due to a lack of research); however, some work being carried out in Germany seems to suggest that it can be useful in combination with other treatments and with an emphasis on self-regulation (Lampe, Mitmansgruber, Gast, Schussler, & Reddeman, 2008).

Whilst these approaches have been effective in treating PTSD, it is unclear how effective they are with CPTSD. This would suggest that while CBT or EMDR could be useful, they might not be enough on their own to effect change. It has been found that problems which are interpersonal in nature do not respond well to this type of treatment (Cohen & Hien, 2006), and that applying PTSD treatment to CPTSD clients could even be harmful if not preceded by work focusing on the toleration trauma-related negative emotions (Courtois, 2008).

**CPTSD-specific Treatments**

Some research has investigated the applicability of CBT treatments for PTSD to CPTSD clients. A randomised trial found that Cognitive Processing Therapy (CPT) (a manualised therapy attempting to alter trauma-related beliefs) and Prolonged Exposure were equally effective in addressing CPTSD symptoms. In this trial, 42% of the sample reported histories of child sexual abuse and the research showed that despite more severe problems with self-regulation, this group benefited to the same degree from either CPT or Exposure. (Resick, Pallavi, & Griffin, 2003). CPT has subsequently been developed into a specific programme which focuses on the symptoms of female survivors of child sexual abuse. This has been found to be effective in reducing both symptoms of PTSD and trauma-related beliefs. These
findings are likely to be robust as the study was methodologically strong and had a large sample (Resick et al., 2003).

Another CBT-based intervention, ‘Skills Training in Affect and Interpersonal Regulation with Modified Prolonged Exposure (STAIR-MPE) (Cloitre, Koenen, Cohen, & Han, 2002, cited in Resick et al., 2003) aims to teach practical skills for emotional self-management in interpersonal contexts as well as distress tolerance and mood regulation, all of which address needs particular to the CPTSD population. Further sessions take a traumatic memory exposure approach. In a randomised control trial STAIR-MPE resulted in a reduction in problems with interpersonal relationships as well as better mood regulation skills and fewer PTSD symptoms (Cloitre, Koenen, Cohen & Han, 2002, cited in Resick et al., 2003). This was specifically for female survivors of child sexual abuse however. An important factor of this trial was that it had a low dropout rate (less than 15%) which could suggest that it is important to focus on skills of self-regulation before working on trauma-specific memories (Resick et al., 2003). This is supported by some of the reflections of other researchers (Courtois, 2008; Ford et al., 2005).

**Treatments Within a 3-Phase Meta-Model**

It has been suggested that integration of different PTSD treatments is an under-researched area, and that it is clinical judgement that is the most important factor in selecting a treatment pathway (Roth & Fonagy, 2005). Research has led to the development of a meta-model for treatment of CPTSD. The fundamental principle of this meta-model is that a client must develop self-management skills and emotional safety in conjunction with the therapist before more CBT-based approaches are applied (Courtois, 2008). This model has been developed based on clinical
observation according to a consensus between researchers adopting a case-study approach (Cohen & Hien, 2006; Courtois 2008; Courtois & Ford, 2009; Ford et al., 2005; Korn & Leeds, 2002; Pearlman & Courtois, 2005). This meta-model could provide a pragmatic framework within which more focused research might be carried out in the future and could ‘aid clinicians and researchers in developing replicable protocols operationalising the model and its phases to rigorously and empirically test the model’s efficacy, effectiveness and utility,’ (Ford et al., 2005).

The first phase of the model involves forming a strong therapeutic alliance and focusing on the client’s safety within that context. This involves working on emotional stabilisation, focusing on areas like suicidal ideation, impulsiveness and dissociative behaviours. The goal of this phase is to develop emotional self-regulatory skills that will facilitate the next phases of treatment (Courtois, 2008).

The second phase focuses more on the trauma itself, and includes revisiting traumatic memories with a view to achieving a more coherent and organised autobiographical memory. This could include exposure and narrative-based techniques which deal with the ‘story’ of the trauma or maybe a specialised technique such as EMDR. It requires the client to make use of the skills developed in the first stage of treatment and not to revert to maladaptive coping styles (Courtois, 2008). Psychoeducation is vital as it both explains the process of treatment and helps clients to understand and manage their symptoms.

The third phase maximizes and enhances the client’s current life circumstances whilst aiming to foster meaningful personal relationships and improving emotional self-regulation. It also deals with the conclusion of treatment and the associated difficulties of loss of security and abandonment (Courtois, 2008). The treatment style
is one of collaboration and joint exploration between therapist and client so that the relationship becomes a functional aspect of the treatment itself. This has a psychodynamic flavour, but does not appear to have been greatly researched.

One reason that the therapeutic relationship is of such key significance is the prevalence amongst CPTSD clients of disorganised or insecure attachment patterns, (Ford et al., 2005). Due to the chronic and interpersonal nature of many experiences of trauma, clients are unlikely to have been exposed to models of emotional self-regulation that allowed their own development of these skills. Some research has also suggested that attachment issues need addressing specifically as part of CPTSD treatment (Pearlman & Courtois, 2005). This should take place within the therapeutic relationship, where work can be conducted that focuses on safety, trust, intimacy, control, affect tolerance, self worth and connection (Pearlman & Courtois, 2005). The assumption is that attachment difficulties can be resolved as a secure attachment to the therapist promotes the development of interpersonal skills, the prevention of self-sabotaging behaviours, such as demanding help but then being ambivalent about it (Ford et al, 2005) and dissociative behaviour management. Psychodynamic factors such as the therapist’s countertransference responses to the clients’ disorganised relational style are also important. (Pearlman & Courtois, 2005). Overall, this approach supports the idea that it is the relationship with the therapist that is most important in successful outcome and also the general consensus that experienced clinical judgement is required to effectively steer treatment for Complex PTSD clients. This demonstrates a fundamental difference to treating PTSD, as it is a recognition that emotional dysregulation is likely to impede attempts at treatment unless it is made a primary focus.
Under the umbrella of the 3-phase meta-model, research shows that interventions targeting specific skill deficits are useful. There are several interventions focusing on self-regulation, improving interpersonal skills and emotional affect regulation. Interpersonal and Affect Regulation Therapies (IATs) are based on CBT but differ from it in several key ways: they prioritise skills for affect regulation rather than cognitive re-evaluation, they use traumatic experiences to explore interpersonal problems and emotions, and they use therapeutic attachment to examine self-regulation (Ford et al., 2005). This marks a moving away from more traditional CBT-based therapies which, being evidence-based, are often privileged in clinical guidelines for treatment.

IAP interventions do not only have to take place on a one-to-one basis. The ‘Trauma Recovery and Empowerment Model’ (TREM) (Fallot & Harris, 2002) is a group psychoeducational programme working on re-establishing the social development that was interrupted by trauma, followed by disclosure and reintegration of traumatic memories into a coherent narrative. This intervention has been associated with reductions in trauma symptoms and improvements in self-regulation (Fallot & Harris, 2002).

Similarly, Present Centred Therapy (PCT) (Ford et al., 2005) and ‘Present-focused Group Therapy’ (PFGT) (Spiegel, Classen, Thurston, & Butler, 2004, cited in Ford et al., 2005) address self-regulation through social problem-solving skills and also use psychoeducation to understand the impact of trauma on relationship issues. A randomised trial shows PCT is associated with reductions in emotional dysregulation whilst a pilot study found that PFGT resulted in a reduction in trauma symptoms as well as other risky behaviours (Ford et al., 2005).
Further interventions focus more on emotional experience. Two group and individual treatments that have their roots in Gestalt therapy, 'Trauma-Focused Group Therapy' (TFGT) (Ford et al., 2005) and 'Emotion Focused Therapy' (EFT) (Paivio & Nieuwenhuis, 2001) focus on traumatic memories of abuse in childhood and promote the overcoming of associated negative emotions. A quasi-experiment found that EFT was associated with cross-domain symptom improvements maintained at a 9-month follow up. A randomised study with survivors of child abuse found that EFT created a significant reduction in reported negative emotions and improved interpersonal skills (Paivio & Nieuwenhuis, 2001) and a pilot study found that TFGT resulted in improved interpersonal functioning and a reduction in trauma symptoms and risky behaviours (Ford et al., 2005). A key emphasis in these treatments is an understanding and awareness of emotion, rather than avoiding it. This fits neatly in with the first phase of the 3-phase meta-model as well as with a consensus of clinicians (Courtois, 2008).

Eye Movement Desensitisation and Reprocessing (EMDR) has been found effective in promoting change in specifically targeted memories in both their positive and negative associations (Korn & Leeds, 2002). This has obvious applicability to traumatic memories. It has been noted that often, CPTSD clients do not meet the required readiness criteria for EMDR treatment in that they often demonstrate dissociative behaviours and emotional lability (Korn & Leeds, 2002). However, a particular protocol in EMDR, 'Resource Development and Installation' (RDI) has been suggested as an effective intervention specifically within the CPTSD meta-model's initial phase which focuses on emotional stabilisation. Whilst evidence for this is only preliminary and must be questioned as it is based on a small number of
case studies, it does seem to lend weight to the case for using a variety of methods within the context of the CPTSD meta-model, and warrants further research.

A further treatment which could be effective for CPTSD is Dialectical Behaviour Therapy (DBT). DBT has been supported as a treatment for treatment of Borderline Personality Disorder (Linehan, 1993, cited in Wagner, Rizvi & Hamed, 2007), and considering that some research suggests that CPTSD in fact embodies many of the experiences and symptoms of BPD clients, it makes sense to consider applying DBT to the CPTSD group.

DBT is principal-driven rather than a protocol-driven (Wagner et al., 2007). This is important in that it allows a degree of flexibility for the addressing of diverse client variables. It also privileges a focus on current functional impairment rather than delving straight into trauma, which fits in with the CPTSD meta-model. It also suggests that improvements in function can be achieved without an immediate focus on trauma itself.

Targeting problematic emotional behaviours which might interfere in therapy is one of the first goals of DBT. Research based on case-studies has suggested that as there is a lack of empirically supported treatments for CPTSD, then an approach such as DBT which is built on principles about promoting change which are empirically supported is the best option (Wagner et al., 2007). Problems which relate more directly to trauma are treated only if they have an effect or impact on current functioning or goals, and they are not addressed until clients have established the ability to tolerate strong emotions. Also, DBT assumes the simultaneous existence of oppositional realities, which represents a tension which is necessary for change to
occur. This seems to legitimize the existence of contradictory emotions, which may resonate with and be useful for CPTSD sufferers (Wagner et al., 2007).

Conclusion

There appears to be a great deal of controversy amongst researchers and clinicians around whether or not CPTSD should exist as a separate diagnostic category and what represents best practice in its treatment. On reflection it appears that there is sufficient evidence for including a separate diagnosis of CPTSD or DESNOS in DSM V. This is both because of what the research literature suggests, and also, thinking in pragmatic terms of how research and interventions are funded, because it would facilitate more targeted research and open treatment doors for what appears to be a significant group of people. However, it currently does not make sense to try and establish a standardised treatment approach for CPTSD when sufferers do not fit into a standard case formulation. Any one protocol-based treatment may not be useful as it might not address the ‘unique constellation of problems and maintaining factors of complex clients’ (Wagner et al., 2007, p.399). Instead, comprehensive theory-driven research needs to be carried out in order to refine hypotheses about CPTSD and improve the evidence base for over-arching themes of treatment.

Currently, a multi-modal and transtheoretical approach appears to be the best way to approach treatment with clients with CPTSD (Courtois, 2008). This would take the form of a working within a meta-model that focuses first on emotional stabilisation, followed by more trauma-focused work, and then finally, skills and self-management for the future. Within this meta-model, other treatments such as specific CBT approaches or EMDR might be included. In practical terms, as the symptom picture for sufferers of CPTSD is so varied, an approach which embraces all current
knowledge in the treatment literature and takes a needs-led approach to designing treatment plans is the most likely to provide positive outcomes. In this way the experience and judgement of clinicians working with the CPTSD population are vital.

The outcome of these debates will have a significant impact on me as a trainee clinical psychologist. Not only will it have implications for the NHS in terms of service provision for this client group, but it will also influence the way I might assess and treat clients in the future. As leadership is increasingly a core skill clinical psychologists are expected to have, I would hope that this approach will allow me to encourage the recognition of this group, as well as to work within an evidence-based model to aim to provide a comprehensive and needs-led service to a group who perhaps are not currently having their needs met.

The CPTSD debate represents some significant issues for psychology: Why are we striving for empirical validation in a population that our profession does not recognise? Will the conceptual ‘bracket creep’ that has occurred in PTSD (McNally, 2003) similarly affect CPTSD? Also, more widely than this, what does recovery mean for clients with CPTSD symptoms? What would it look like and how could it be conceptualised? Presumably if symptoms and circumstances are so diverse then recovery would look very different depending on the client. It follows that unless aiming for the same goal, measuring treatment outcomes for this population will remain difficult. It is also important to note that the research literature lacks diversity in its ethno-cultural focus, and it may well be that what researchers describe as CPTSD differs in its presentations, conceptualisations and meanings in different cultures and populations. Further research is needed to address this.
However, whilst this debate continues, there remains the issue that whilst we are waiting for research to legitimise and support both diagnosis and treatment, there are plenty of distressed clients who are in need of help.
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Jackson


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Professional Issues Essay:

*How do you see ‘recovery’ operating for children, older adults or carers?*
According to Mike Slade, author of '100 Ways to Support Recovery: a Guide for Mental Health Professionals' (Rethink, 2009), recovery is a "... process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness." How do you see 'recovery' operating for children, older adults or carers?

The idea of recovery as a philosophy of care within mental health is one that has been gathering weight in recent times (Roberts & Wolfson, 2004). It appears in service philosophies (Surrey and Borders Annual Plan, 2011/12), in national health policy (Department of Health, 2011) and also in the service user-led ethos of third sector organisations such as Rethink. Recovery has also featured in the media as something we should be moving towards (Guardian, 2010). However, despite this growing cultural currency, it seems unclear exactly what recovery means. What do different people understand by the word 'recovery?' What implications might this have for service organisation and the work of professionals such as clinical psychologists?

Whilst these issues are important for mental health across all sections of society, this essay aims to address them within the specific context of older adults. As the population of the UK is ageing, the health of older adults is something of increasing concern. It is anticipated that by 2021 there will be over a million people suffering from the dementia in the UK. (Alzheimer's Society, 2011). Aside from this, the very fact that people are living longer means there are more people in later life needing support with other mental health issues such as anxiety and depression, particularly
in the context of changes in identity as they age or if they experience losses within families and friendships. There is a dearth of research about how recovery might look within such a heterogeneous group, but in order to be prepared for the challenges of caring for this population in the future, it is important to consider how concepts such as recovery might help maximise resources, consequently giving older people the best possible opportunity to continue to live fulfilling lives whatever their health status.

A consideration of how recovery might operate for older adults needs to consider what it might be that they are recovering from. Although this raises many questions about the nature and definition of mental illness (a point to be returned to later), I have chosen to focus here on four areas: firstly, the context of recovery-oriented practice; secondly, how recovery might operate for an older adult suffering from depression; thirdly, the challenges that the concept of recovery faces when considered in terms of degenerative conditions such as dementia and lastly, the impact of taking a recovery approach for staff working with older adults. I have at times drawn on my clinical experience in addressing these questions and also to promote reflexivity in my thinking.

The context of recovery in mental health: From national policy to the role of clinical psychologists

The idea of promoting recovery is one that is supported by developments in national policy over the last few years. Research carried out by The Sainsbury Centre for Mental Health (SCMH) which contributed to three policy papers between 2008 and
2009, set forth key recommendations for recovery-oriented practice. These included themes such as personal empowerment and person-centred planning. Replacing the National Framework for Mental Health, the document ‘New Horizons: A shared vision for mental health’ (DoH, December 2009) privileges the concepts of ‘hope, self-determination and opportunity’ as well as the ‘partnership between service user and practitioner.’ (p24) as being of fundamental importance.

At the level of policy then, it seems that the concept of recovery is about a wider understanding of how services as a whole might promote mental health more effectively. Ian Macpherson, writing in 'Looking Ahead: the next 25 years in mental health' (SCMH, 2010) remarks that ‘We need to remember that recovery is not just about individuals, but how we collectively engage in promoting changes that make a real difference, rather than allow current pressures to reinforce professional or organisational territoriality.’

What emerges from these shifts in policy is that we are (or should be?) moving away from a medical model of mental health. Taking a recovery-oriented approach offers increased quality of life and better social inclusion for the individual through reduced stigma, greater understanding within the local community, and changes in services and professional approaches. Considering that it is expected that a fundamental aspect of the work of a clinical psychologist will be taking on leadership roles (New Ways of Working, British Psychological Society, 2007), it is important to consider how the work of psychologists might fit into this framework, for example by promoting person-centred planning within multi-disciplinary teams. It is evident from the policy papers mentioned above that whilst the broad theme of recovery-oriented practice is endorsed, it is not often expanded upon in terms of what this
means for the everyday life of individuals or how professionals might go about encouraging this approach with clients. As clinical psychologists also have a responsibility for the supervision of other staff, a consideration of practical ways in which clinicians can promote recovery-oriented practice with clients is also vital.

What does recovery mean to whom? The perspective of older adults

In the Rethink document in the title of this essay, the concept of recovery appears to have two parts. Firstly, it is a movement involving a change in attitudes towards mental health issues and secondly, it is a movement towards allowing service users to lead a more personally fulfilling life. It is of course important to understand cohort beliefs when considering how the recovery movement might be understood by older adults. This is in itself problematic, as the group we define as ‘older adults’ may themselves reject this label, and indeed such a group may encompass a wide age range and clinical profile. In my clinical work with older people, I asked some clients about what recovery means to them, and their answers varied from ‘it just means getting on with things’ to ‘It means I would be like I was 25 again,’ which demonstrates the uniqueness of individual understandings of the word (these comments are included with clients’ consent).

The very use of the word ‘recovery’ carries an implication that someone has been ill or had something ‘wrong’ with them, which is a conceptualisation of mental health problems that might be challenged on social constructionist grounds: Exactly who is mental illness a problem for in the first place? (Bentall, 2009). However, there appears to be a larger shift within mental health philosophy which seeks to challenge the medical model of mental illness where people are ‘treated’ for ‘problems’ as they might be if they had physical health issues. Indeed, it could be argued that it is only a
historical accident that our understandings of mental illness are on a par with physical disorder, and that such a conceptualisation has actually hampered both our understanding of mental health issues as well as the ability of those suffering from them to be able to live their lives in the best way that they can (Bentall, 2009). However, some have also argued that to view social and medical models of mental illness as in direct opposition to each other is an unhelpful distinction, based upon a reaction against a caricature of inhumane psychiatric practice of the past (Shah & Mountain, 2007).

The idea of recovery-oriented practice is caught up in such a debate. It is a particular time-bound cultural and political framework that supports the idea of a recovery model, and in discourses about this, it is positioned as the ‘right’ approach. However, in the case of older people, such a framework could seem alien or even unhelpful. In my clinical placement, I have found that some older clients have appeared bewildered by the idea of working collaboratively with a psychologist, have referred to me as ‘the doctor’ (despite my explaining my trainee role to them) and appear to be strongly influenced by (and comfortable with) a medical model’s understanding of their problems. A client I have been seeing for obsessive compulsive disorder (OCD) felt that ‘just talking’ would not help her as she was ‘mad’ and needed medication to get better. Explaining the rationale and evidence base for CBT for OCD to her, she felt that if this treatment couldn’t ‘definitely cure’ her there was no point trying it. Further, she found it difficult to see how she might be able to live a fulfilling life in spite of her problems.

This seems to raise an interesting ethical dilemma. The older people I work with have had a very different cultural experience of understanding mental health to me.
Sometimes older adults who are used to being treated within a medical model may feel under-supported if the professional with whom they are working does not take a ‘lead’ role directing the person towards things which will ‘cure’ their problem. If the concept of the recovery model as I understand it does not fit in with their understandings, should I be trying to fit them into this model at all? This has implications for diversity as well; although it might be in contradiction with current best practice to hold a more medical model of mental illness, surely it would be important to respect the diversity of views on this and in the true spirit of patient-centred care, adopt a way of working that the client feels comfortable with? After all, true person centred planning would need to accept and validate a person’s preferred way of receiving services, whether or not these are in line with current trends in mental health policy.

It is in the midst of dilemmas such as these that I believe the real challenge is in conceptualising recovery for older people. It has to be about what it means for the individual concerned even if that might feel like it is out of synch with the recovery model itself. This may seem like a contradiction but I think it is one that has to exist in order to engage fully with the true spirit of recovery. Perhaps this circularity is a weakness inherent in the recovery model as a concept.

Problems in applying the recovery approach

This seems to be a subtlety that is under-explored in the Rethink document ‘100 Ways to Support Recovery: a Guide for Mental Health Professionals’ (Rethink, 2009), and is part of what seems to be conflicting cultural messages around some of these issues. One example is where Slade states that people with mental health problems are ‘normal’ and want to do ‘normal things,’ yet a few paragraphs later
goes on to stress the importance of the uniqueness of every individual’s pathway to recovery. It is difficult to see how anyone could define what is ‘normal’ and what a ‘normal’ thing to do might be. I would argue that this is still embodying an attitude of stigma as it seems to be saying an individual recovery journey is important, as long as the things you want to do fit in with what everyone else in society thinks of as normal.

However, this idea of accessing ‘normal’ life is disputed within the recovery literature itself. Deegan (1996) has defined the goal of recovery as ‘not to become normal. The goal is to embrace the human vocation of becoming more deeply, more fully human.’ Slade (2009) conceptualises recovery as an approach which should include the development of hope, a strong sense of personal identity, supportive relationships, empowerment and social inclusion. It is interesting to note that these things are being positioned here as ‘good’ things that a person ‘should’ strive for. Whilst of course this may be the case, I believe it is important to consider issues of diversity and difference here, as it could be argued that in some cultures (of which there are representatives within UK mental health services), individual empowerment might not be viewed as important as being part of a collective community, as independence is not prized in all cultures.

Slade states that for the Rethink document, he gathered his thoughts from recovery practices in Europe, the US and Australia. This of course raises the question that it might be possible to learn something about the diversity of meanings and understandings around recovery from non-Western cultures. Given the increasing diversity of the UK population, and the importance of achieving ‘cultural
competence' within UK services this seems an important point which could be explored further.

**An example of recovery in older adults - Wellness v illness: Retelling the story.**

Perhaps the most useful way to conceptualise recovery for older people is looking at how it focuses on wellness and not on illness (Slade, 2009). Rethink (2009) highlights both self-identity and meaning as key aspects of this. These two concepts are particularly useful in thinking about depression in older people. In the National Service Framework for older people, The Department of Health estimates that 10-15% of the population aged over 65 has depression, (DoH, 2007). Whilst I acknowledge that there are other approaches to treating depression, I have chosen to focus in detail here on how meaning-making might operate within a recovery framework.

In Erikson's psychosocial model of development over the lifespan (Erikson, 1968) older adulthood is understood as a period of reflection on life, where the task is to look back over experiences and feel a sense of fulfilment. The conflict at this stage is between ego integrity and despair; a successful resolution would lead to feelings of wisdom and fulfilment, otherwise there may be distressing feelings of regret. Erikson's theory has been criticised for portraying identity stages across the lifespan as sequential and tied to a particular age range and for not allowing for change and fluidity across different life stages (Brown & Lowis, 2003), which could be problematic for older adults with diverse life experiences. However, Erikson argued that the phases are not solidly boundaryed but represent times where a conflict is more prominent (Erikson, 1968).
Evidence suggests that such feelings of unresolved conflict may play a key part in the maintenance of depression in older adults (Laidlaw et al, 2003). Since both self-identity and meaning making are vital components of recovery (Rethink, 2009), it makes sense to look at approaches to working with older people that can promote a sense of review and integration.

It has been argued that there has been an over-reliance on medication to deal with depression in older adults, and that offering the person the chance to seek personal growth in their later years, through acceptance and integration is actually more beneficial (Butler 2002). Research shows that an effective intervention for depression in older adults is reminiscence therapy, where clients are invited to reflect on various aspects of their lives with a trained therapist (Scogin et al, 2005). A meta-analysis of fifteen controlled outcome studies (Bohlmeijer et al, 2007) found that there was a moderate influence of reminiscence therapy on both emotional wellbeing and life satisfaction. Specifically, it was found that an overall life review (going back over the person’s life and discussing points of regret and conflict with the therapist) was most effective. Although there has not been a great deal of research into the overall effectiveness of life review therapy, it appears to have positive outcomes (Haight, Michel and Hendrix, 2000).

Life review therapy directly supports recovery within an older adult population, as it aims to reduce depression, increase life satisfaction, improve self-esteem and self-care and support the person in coping with losses. It also offers an implicit acknowledgement that a client is the expert on their life, as well as providing opportunities for them to observe and acknowledge ways in which they have demonstrated mastery skills across a variety of life situations.
A related approach that promotes recovery in terms of meaning making amongst older adults is narrative therapy. From a social constructionist position, narrative approaches hold that the stories people tell about themselves are of central importance to how they understand the world and their position within it (White & Epston, 1990). For an older adult, this might mean that their stories about themselves are very much shaped by the point in cultural and social history at which they occurred. This approach could facilitate recovery by encouraging clients to replace dominant ‘problem-saturated stories’ (White and Epston, 1990) with more empowering stories about their lives. For example, dominant discourses around mental health that an older person might have grown up alongside could suggest that, if they experience any mental distress, it is they themselves that is the ‘problem’. Inviting them to identify occasions on which they have overcome the ‘problem’, a ‘unique outcome’ (White and Epston, 1990), allows them to challenge versions of events that they may feel conflict or regret about.

Research shows that a key feature of depression is a feeling of a lack of control, and that the ‘learned helplessness’ that arises from this is central to the maintenance of the cycle of depression (Seligman, 1975). This is a particular issue for older adults who may feel that their problems are so long-standing that they are too difficult to challenge. This is one reason why promoting recovery amongst this group is both a challenge and an imperative. Narrative approaches to depression can be of great use here as they allow an externalisation of depression as being something separate to the person themselves (White and Epston, 1990). This also fits into a strengths-based model which is supported by the recovery ethos in general.
Research has found that narrative approaches are also of benefit to the family and friends of the older person (Etchison and Kleist, 2000). This in itself allows recovery to operate at a more systemic level, which is particularly salient given the potential strains on carers of older adults with mental health problems. Recovery-oriented practice fosters a community approach and encourages people to use existing support networks. This could be a problem for older adults where a loss of networks as they age is likely, leading to an increase in isolation. Therefore supporting families and carers is vital in preventing an over-reliance on services. It also presents an opportunity for greater collaboration with Third Sector organisations.

Whilst narrative approaches towards depression in older adults might help promote recovery in a meaningful way, they are not without criticism. The most significant limitation is perhaps the lack of empirical research to further explore and validate the claims that such approaches are effective. As narrative therapy focuses on qualitative outcomes, it is difficult to measure its successes in line with other interventions which have been more widely explored (Etchison & Kleist, 2000). This is an area which future research could address.

Establishing an evidence base could be part of a wider challenge for recovery-oriented practice in general. In an economic climate where Payment by Results (DoH, 2011) challenges services to provide concrete and measurable outcomes for interventions, it is difficult to see how client-determined outcomes will be captured and used, and how approaches such as narrative could be developed further.

**Staff perspectives on recovery in older adults: ‘But what do we actually have to do??’**
Slade also addressed the impact of a recovery model on staff working within services (Rethink, 2009). This is of vital importance as it falls to staff to support people in their recovery journey. Given the complexity of cases that mental health professionals are confronted with, it can sometimes feel that unmeetable expectations are placed on staff in terms of both logistics and resources. Understandably, such expectations could create anxiety. A recovery approach has the potential to liberate staff from these expectations and empower them to promote ways of working which are not about ‘us’ and them’ or illness and cures, but more about helping people to live their lives in the best way that they can.

Although Slade claims to offer practical suggestions (Rethink, 2009), these are generally things like ‘support the person in accessing’ something, for example, community leisure services. Of course, this is all well and good in an NHS which is adequately resourced and staffed but that is clearly rarely the case. The document does not seem to address the issue of needing to empower staff before they are able to empower patients themselves. Basic issues of time and staff numbers might prevent people working in care settings from being able to facilitate a recovery approach as well as they might. It is for this reason that for a recovery approach to be effective, it would need to operate at a national and systemic level and be supported with adequate training and resources.

It could also be argued that in some ways it might be difficult for staff to follow a recovery approach because it is perhaps naturally more comfortable to seek discrete solutions to problems than to manage the messy uncertainty of everyday life. Finding ways of managing this uncertainty in a safe and productive way has been a key theme of my clinical practice so far in training. Mason (1993) describes ways in
which positions of ‘safe uncertainty’ can be worked towards that go some way to make this conflict more manageable. He describes how the drive towards seeking certainty can result in a paralysis in development and a lack of creativity in clinical work.

There are other perspectives on this. For example, Menzies-Lyth (1959), described the hospital as a social defence system that represented an institutionalisation of primitive anxieties. She described how the ‘role’ of the nurse is equated with the ‘task’ of care, which is seen as keeping the patient alive, clean and nourished. However, she argues that this structure neglects both the nurse’s and the patient’s emotional needs. This model could be applied to care settings for older adults suffering with dementia, where the basic ‘tasks’ of care may prevent a more productive interaction between staff and patients, which compromises the recovery model’s potential. It also suggests that a more reflective practice approach amongst staff working in care environments may go some way to minimise this risk. This is very relevant to the work of clinical psychologists, whose roles in consultation and supervision work could allow them to facilitate moves towards greater exploration of these challenges in working with older adults.

The recovery model and dementia

One area of practice that challenges the remit and applicability of the recovery model in older adults is that of dementia. This has not been greatly addressed within the recovery model literature (Martin, 2009). Around 750,000 people in the UK are suffering with dementia, at an estimated cost of £20 billion per year. By 2021 it is estimated that there will be over a million sufferers (Alzheimer’s Society). These
statistics highlight the extent of the problem in the UK alone, and, as people live longer, the challenges that accompany this loom ever larger. Adams (2009) observes that the degenerative nature of dementia and the way in which sufferers are often placed within long-stay institutions has resulted in a ‘therapeutic nihilism’ where, removed from their families, they experience nursing care which is depersonalising. Adams asserts that this is due to the view that recovery is not possible for people with dementia.

However, things are changing. Martin (2009) asserts that the

‘medical model approach to care needs to be challenged. This philosophy only serves to meet the needs and demands of the system rather than those of the people with dementia’.

He goes on to say that:

‘focusing on people rather than services, emphasizing strengths rather than deficits and... fostering collaboration between those who need support and those who support them is the most important component to a recovery oriented approach.’ (p658)

This highlights the importance of considering and exploring how to adapt a recovery approach to working with dementia. Perhaps in such a context, the concept of recovery must be realigned. Acknowledging that dementia has clear limitations on people’s expectations, The National Institute for Mental Health in England says (2004) that the aim of recovery in dementia is to:
'recover optimum quality of life and have satisfaction with life in disconnected circumstances'.

This highlights that the concept that recovery does not mean 'cure'. In this context, it is concerned with working towards an optimum that the person can hope to achieve, and maintaining their quality of life and capacity to make choices as far as possible. The recovery approach in dementia has been linked to the importance of person-centred care (Martin, 2009) and the importance of staff working with dementia sufferers taking a holistic approach. This is reflected in a recent NHS campaign which encouraged people to see their doctor if they experienced any dementia symptoms. However, at the same time it emphasised that there is more to a person than their dementia. The phrase 'I have dementia but I also have a life' goes a long way to endorse this view (Department of Health campaign, 2011).

However, although the idea of person-centred care for dementia is not a new idea, (Kitwood 1997) and has been reflected in dementia literature over the last ten years (Martin 2009), there is also a suggestion that such theoretical models have not necessarily been reflected in the actual experience of those living with dementia either in residential care or in their own homes. This disparity between theory and reality is a point that could be levelled at the recovery model in general, but it seems particularly pertinent to dementia sufferers because of the vulnerability of this group. Martin (2009) relates this to the prevalence of the medical model in seeing the dementia before the person, and, the debate around the usefulness or otherwise of pitching the medical model against the recovery model notwithstanding, it is this
kind of fragmented thinking that the recovery model in a general sense seeks to address.

Martin cites the ‘Tidal Model’ as being a useful framework through which to look at recovery in dementia (Barker and Buchannan Barker, 2005). Although not specifically designed for application with dementia sufferers, this model, with its focus on collaboratively supporting people when they are at their most distressed, as well as its privileging of clients’ own voices and wisdom, encourages people to lead their own recovery regardless of the limitations of illness. This allows the person’s quality of life to be maximised, and, above all, values their experience.

Repper and Perkins (2003) have suggested a model that goes some way to addressing the specific needs of a person with dementia. They define recovery as something which is both personal and relational, and which takes place in a social context where relationships with other people and agencies is key. They highlight the connections between three key areas of recovery.

The first focuses on ‘personal adaptation to circumstances’, and whilst it is acknowledged that individuals may vary in their cognitive capacity to address this, they can at least be optimised with sensitive person-centred care. The second area is ‘creating hope-inspired relationships’ which includes relationships with carers which foster valuing and listening to the person, and authenticating their personal experience. This includes thinking about the communicative acts that may be inherent in things people say which don’t appear to make sense, such as people asking for their parents, who may be long dead. This also allows an understanding of challenging behaviour in the context of communication of unmet need rather than as
deliberate aggression which could consequently have a profound influence on relationships between staff and clients.

The final area, 'promoting access and inclusion' highlights the prevention of institutionalisation or isolation of a person with dementia. This allows the facilitation of recovery in a way that is both realistic and that also maximises the quality of life. Case studies detail anecdotal reports which seem to evidence this (Martin and Younger, 2000).

Martin (2009) asserts that for a recovery-oriented approach to be successful, a change in the prevailing culture that dominates in some care settings would need to occur. However, research has shown that if such care cultures are changed, then the impact on individuals can be far reaching. For example, in one case study, a cultural change towards more person-centred care resulted in one elderly resident who had been sleeping for large portions of the day becoming much more alert and taking a more active role in his life (Martin and Younger, 2000).

There are diversity issues to be considered here. Adams (2009) makes the point that some cultures have negative views towards people with dementia which are enshrined in their languages, and that it is difficult to promote a recovery approach without an accompanying positive attitude. This suggests that in a wider sense, the attitudes of society are vital in promoting recovery in dementia.

Of course, the recovery approach within dementia is not without its criticism. Some professionals might fear that promoting the hope of recovery is false, unrealistic, and is colluding with denial of illness. Martin (2009) acknowledges that a recovery approach works most effectively with those in the early stages of dementia and that
there are limits to its application. However, this need not be the case for adopting a person-centred approach as a whole. The challenges that this presents to the care system and the importance further research and attitude change are clear.

Conclusion: How do you see recovery operating for older adults?

Whilst a recovery approach is firmly enshrined as a philosophy of care amongst working age adults, it has not been applied greatly to older people (Adams, 2009). It is clear that the way in which recovery might operate for older adults depends very much on what recovery might mean to the individual and what their particular context is. It is within this variability that I would argue a 'true' understanding of recovery lies. It includes taking a pragmatic approach that is genuinely person-centred whilst respecting the way in which a person wants to receive services even if that seems to contradict the approach itself. These debates and dilemmas have been highlighted for me in clinical practice.

Whatever the older person's mental health problem, from depression to dementia, a recovery approach offers a way of maximising a person's current life opportunities whilst allowing them to make sense of the past in a coherent narrative. It encourages and facilitates a person's ability to lead a fulfilling life but is also mindful of their limitations and acknowledges the process of ageing. To be successful, a recovery approach needs the buy-in and support of the client themselves, of their families and carers, of the staff, who work with them, of services, and, of course, in the current climate, is economically challenging. Further research is necessary to explore in greater detail exactly which approaches might maximise the applicability of the recovery model in specific therapeutic areas.
However, whilst the challenges for resources and staff are acknowledged, it does not necessarily make sense that a great deal of these are required to operationalise recovery-oriented care. It is more about challenging attitudes which unnecessarily limit a person’s capacity to live a fulfilling life. As changes in mental health care culture can be slow, and given that an older cohort will have been familiar with a more medical model, it might be that there are particular challenges in adopting a recovery approach for older adults. However, whilst recovery-oriented care requires a significant cultural shift both in society and within services, just considering what some of these concepts really mean to an older adult population at least opens up the possibility of promoting their greater wellbeing.
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Problem Based Learning Reflective Account 1:

*The Relationship to Change*
Reflection on Reflection

This is the first time I have done any reflective writing. It was clear from the start that reflection is a significant course component, but it felt that it would be a luxury, the kind of thing that I might do once ‘everything else’ was completed. However, it has become clear to me how useful reflection can be, and I have seen whilst on placement how it has helped me to learn and develop. I hear my supervisor refer to ‘reflective space’ a great deal, and this has become how we view our supervision sessions: The strong emphasis she places on reflecting on the interface between the personal and professional within clinical practice, and using the subsequent ethical issues that arise has been immensely useful and has given me confidence in my professional development. This approach has also promoted the holistic view I would hope that I take when working with clients.

The PBL exercise

Meeting our PPD groups and beginning work on the PBL exercise was quite anxiety-provoking for me. Starting the course itself was quite a difficult time, and I experienced a mixture of feelings: A sense of achievement and pride at having been accepted on the course, concern about my capacity to do it, and worry about fitting in with the other trainees. Having a relatively unstructured task immediately brought these anxieties to the surface.

Our group chose to look at change in terms of how a multi-disciplinary NHS team might handle changes in local policies and procedures following a new directive by the Department of Health. Our aim was to show the impact of high level change on local practice, from a systemic perspective. Additionally, we wanted to explore how
the way in which change is managed can impact on how those whom it affects integrate it into existing practice.

Following an initial brainstorm, the group divided the topic into areas for individual research. We discussed and refined ideas and developed the idea of a role play-based presentation as a vehicle for exploring these issues. This grounded theory approach was a strength of the group, as it ensured everyone contributed to the development of the idea for the presentation from the collection of a wide range of data. As the group members all had diverse experiences of working in the NHS, it felt like an approach that everybody could contribute to.

The process of selecting our approach was interesting, as we were very democratic in the way we considered and discarded subjects, and there was a real sense (I felt) of people being more focused on the social integration of the group than the content of the task itself. I felt quite aware of the way in which certain group 'roles' came to be filled each session, and I don't think I was alone in considering what psychological research on group processes might say about how we were working. This issue arose again in our final presentation where the only male in the group played the part of the team manager. We were asked about the stereotyping here, although I felt it was more that this role was one of the larger ones and the male trainee was keener on role plays than the rest of us!

I felt that we were all highly motivated to achieve a good outcome for this task, and as research has shown that motivation, interaction and productivity are positively associated with each other within PBL groups (Nieminem, Sauri, & Lonka, 2006), I
think that our anxiety about wanting to make a good impression at the start of the course actually contributed to our group’s successful outcome.

Some of the initial anxiety in the group about whether we were doing the right thing or not (something that frequently occurs to me on placement) combined with the unstructured nature of the task seemed to become a weakness for the group, in that it felt at times that it was a struggle to get going. Our concern to be democratic about everything also I think stifled some of our creativity, so what began as a strength in some ways turned into a weakness. As we got to know each other better many of these anxieties subsided, and a lot more humour was deployed to the point where we started to relax and almost enjoy ourselves.

When we delivered our presentations the order was changed, so that instead of going last we were first. On reflection I can see this was a useful experience, as often in clinical practice there is a requirement to deal with the unexpected calmly and coherently. A particular example of this would be where a client who was hearing voices arrived at the day hospital where I work, evidently distressed. There had been reports from his neighbours and the police about some erratic behaviour. Decisions had to be taken quickly about the best course of action, and although I did not play an active part in that, it was useful to see how the team members dealt with the situation.

We received positive feedback for our presentations, and I feel that the exercise helped our group to gel. We built up trust and empathy which will undoubtedly be useful for facilitating discussions throughout our training. I think working with our cultural genograms enhanced our sense of connection to each other, and also
promoted awareness of diversity in what superficially might look like a relatively homogenous group. This is particularly important in considering diversity in clinical practice, as it has made me think that an appreciation of diversity is more than an awareness of ethnicity or nationality, instead involving many other complex and interdependent factors which contribute to our uniqueness of perspective, and that the same will be true of clients.

**The PBL exercise and clinical practice**

Being aware of wanting to fit into the group successfully and address the task competently made me feel some early group sessions were quite artificial. This might have been simply because we didn’t know each other well. This is important for clinical practice, where it is common to meet a new client for an assessment, and expect them to talk about personal and often distressing information with me, a total stranger. Knowing how uncomfortable discussing things (and not even personal things) with people I don’t know could make me feel has been useful, as I have reflected on the anxiety and possible ambivalence a client might feel in sessions.

Additionally, I worried that I was too passive in group meetings and that this could be interpreted as unfriendliness or disinterest. I am shy, and find speaking in groups sometimes stressful, as I often feel myself start to blush and think I must look very red. Some of the course teaching about social anxiety and CBT approaches to it had made me think about possible ways to tackle this issue, especially considering that CBT can be effective in treating it (Roth & Fonagy, 2005).

This issue was particularly salient on placement, as I felt that in team meetings I did not contribute much, and this compounded my worry that other team members might
view trainees as people who use resources but don’t give much back. My supervisor encouraged me to contribute in meaningful ways to meetings, and I think she did a sort of behavioural experiment by stealth where on one occasion she asked me to comment on something, which I did, and I didn’t go red and lose my voice as I had feared, but instead got positive feedback for my contribution. As well as being useful on a personal level, I felt that the experience of actually going through the type of process I might suggest for a client with an anxiety problem was very important for developing a sense of the client’s perspective. I think this ‘putting myself in the client’s shoes’ is a very effective way for me to learn, and enhances my ability to form effective therapeutic alliances.

**PBL exercise/NHS issues**

Our choice of topic itself felt quite relevant to the position we find ourselves in as trainees. Our presentation demonstrated the anxiety around forthcoming changes to the structure and delivery of services, something palpably relevant to our placement work. In my trust, I don’t think the potential impact of the cuts in spending has been felt in the same way as in others, but it raises interesting questions about my position. It feels strange to be in a job which is (relatively) secure for three years, when colleagues don’t know if they will still have jobs in a year’s time. It also feels like we are in such privileged positions to be paid to train, considering how difficult it is for people to afford to go to university these days. This makes me mindful of how the role of trainee could be problematic for other employees who don’t have the same support or privileges. Consequently, it made it feel more important to get to know other team members and try to understand their concerns and frustrations around the future of their jobs.
The PBL exercise allowed the consideration of ethical issues which are relevant in clinical practice. An example of this is the complexity of managing what needs to be done, whilst considering the diverse views of professionals and service users about what should be done, and being mindful of the economic reality of what can be done. In the PBL this took the form of some MDT members perceiving that their work might be affected by changes in what was demanded of them. We explored the conflict that can arise in such situations around the issue of unmet need in the light of a lack of resources. A related example from my clinical practice concerns a client diagnosed with Asperger Syndrome. It seemed she did not fulfil the criteria for this, but instead used it as a barrier between her and the social world. However, having such a diagnosis also allowed her to claim disability allowances that she might not otherwise have been entitled to. This raised an ethical issue for me, as the diagnosis was both of use to the client and simultaneously restricted her. Where my position as a professional impacted on this was something I discussed extensively in supervision.

Wider issues

It is clear that a major expectation of us as trainees is that we work within the scientist practitioner model. I think this was something people worried about in our group, in that we felt the need to ground our presentation in theories of change, almost to legitimise the content in some way. I think this issue is relevant for the discipline of psychology as a whole. Sometimes it feels as though we are so intent on proving that we are as rigorous as other ‘scientific’ disciplines, that the interested of those at the centre of our work, our clients, can be overlooked. This perhaps also reflects the conflict between academic expectations, and what brought us into the
profession in the first place. For me, clichéd though it sounds, this was a desire to alleviate distress in others (although what that means about me would be interesting to reflect on). The pressure to maintain links with an evidence base at times feels like it could stifle the energy for original thinking or ideas – even though surely an evidence base has to start from an idea that doesn’t already have one! These issues have made me think about the importance of ensuring that the client drives theory, not the other way around. Theory can guide practice but shouldn’t dictate it.
References


Problem Based Learning Reflective Account 2:

The Stride Family
Context

I have found it particularly useful to reflect upon the work of our Personal and Professional Development Learning Group (PPDLG) this year in the light of how it has developed since the first year. Using this approach not only allows me to track my own personal development during this time, but also offers a way of linking my new learning to clinical practice. In this way I have been able to consider what I have achieved so far, how the PPDLG as a whole is developing, as well look towards developmental objectives for the next stage of my training.

I have chosen to structure this account by reflecting under three headings: The group, the task itself and then finally, the presentation. Also, I was on annual leave at the time of the actual presentation, and I have addressed this in a separate section at the end.

The Group: Moving on from year 1

Group members said they feel more comfortable in the group this year (I plan to return to the reasons for this in more depth in the Process Account to be submitted later). This positive change was reflected in the whole experience of the PBL task for me. In a reflective discussion which took place after the presentation had been delivered (and good feedback received), people commented that they had both enjoyed and gained more from this year's task compared with last year's. Although this may be partly due to feeling more relaxed and confident with each other and with training in general, we considered whether this might be related to the group moving from the 'norming' stage of development towards 'performing' (Tuckman, 1965). This seemed to be evident from how the experience of preparing the
presentation felt more smooth, organised and efficient than last year, and people expressed less anxiety about it. This was also reflected in the easy and ‘natural’ way tasks were divided and shared.

It was noticeable (and something we discussed in reflective discussions) that our group did not appear to evolve a clear leader, but that people took on this role interchangeably. This allowed us to benefit from each others’ areas of strength and knowledge. However, leadership is a particularly relevant issue for clinical psychology as a profession now and in the future, and in order to meet this challenge, it is something that we need to engage and feel comfortable with.

It was also apparent that people were quite self-deprecating about their own contributions in terms of knowledge or skills. I found this useful to consider in terms of my role in clinical practice, as I struggle sometimes to have confidence in myself. This is an ongoing developmental need for me and something I have discussed in supervision.

Whilst I know I have worked long and hard in mental health contexts before securing a place on training, I still sometimes feel like I know nothing and am underqualified to do the job! On my current placement, in older adults, this has been a particular issue. One client expressed reluctance to be seen by a trainee, as she said that her problems had been going on for sixty years and so she needed someone who ‘knows what they are doing!’ This presented an ethical dilemma for me, as on one level, I entirely understood her position and felt that had I been her, I might have reacted similarly. However, I also knew that I was competent to work with this lady, even though I might suffer from a lack of confidence at times. After discussion in
supervision, I dealt with this situation by being open and honest with the client; by expressing an understanding of her concerns, by explaining the role of a trainee and the process I had undergone to get there, and by taking a collaborative exploratory approach with her problems. I think this approach was effective as it contradicted an image of mental health services that she had held previously which was very much along the lines of the medical model. Although she hadn’t experienced this collaborative approach before, she engaged with it, and this allowed us to build up trust and form a productive therapeutic relationship.

The task: Complex case, complex emotions

Our task was to complete a full risk assessment for twins who had been placed in foster care following reports of emotional abuse, and also to assist the court with a rehabilitation plan if appropriate. The twins’ parents had learning disabilities and the local authority had begun adoption proceedings.

Our approach to the task was to brainstorm key areas and then look at the legal framework and evidence base for these. We were clear from the start that we wanted to remain child-focused, and to pay attention to the various competing contexts in the scenario. We were also mindful of the need for the various professionals involved in the case to work in a synchronised way. The issues involved made the task emotive, and I was mindful of the potential for personal resonances for group members.

I think we initially felt overwhelmed by the sheer complexity of the task and the many different strands of information to consider. What struck me clearly above all else, was the importance of considering different perspectives on the ‘problem,’ which is something that I try to do in my clinical practice.
It was the consideration of the varying perspectives on the situation that led us to consider using sculpts as a way to represent this. Sculpting has been used in family therapy as a way to explore the complexities of relationships and explore alternative perspectives on a problem (Lebow, 2005). I found it a particularly useful way to explore ideas about the task as well as to present them to the cohort, as it invited us to challenge our preconceptions about issues of disability and parenting. It also led us to view as paramount the importance of giving a voice to the family, and individual members within it, ensuring an exploration and appreciation of diversity.

This approach also made me think about how we conceptualise ‘problems’ as a whole. I felt it was important to consider within the task exactly what was a problem and for whom. Although I haven’t done my learning disability placement yet, I used to work in a respite care home for people with learning disabilities, and often felt that staff and families described clients’ behaviour as a ‘problem’ when what it seemed that they meant was the behaviour was a particular problem for them. This has been echoed in some consultation work I am doing on my older adults placement in an inpatient ward for people with dementia. A man collects things from around the unit to push around in his trolley, and staff try to stop him from doing this. One staff member felt this was a problem because it made the ward untidy. I was left thinking that, as long as there were no risk issues involved, was his behaviour really so much of a problem after all? This has obvious implications for person-centred care.

I think that during the task we were anxious about finding the ‘right’ answer, and this is an anxiety that is definitely paralleled for me in clinical work. Whilst last year, I felt anxious about being competent enough to fulfil the requirements of training in general, I think this has been replaced by anxiety about working with new client
groups who have different and complex needs. Since last year, I have been able to rationally address these feeling around competence by learning to be comfortable with uncertainty and understanding that there is rarely a clear ‘solution’ to a client's difficulties. This is something we reflected on in a previous PPDLG meeting when we considered how adopting a position of ‘safe uncertainty’ can address these anxieties whilst still allowing creativity and innovation in work with clients (Mason 1993).

Perhaps one result of feeling anxious about doing the ‘right’ thing in relation to the task was that we made the presentation more research-focused than last year. I think this is partly due to us wanting to maximise use of the learning experience, but I also feel it is because we are feeling more comfortable and competent with integrating research with our own experiences as we adopt the scientist-practitioner model of working. Also, the task fell at the same time that there were other academic pressures, and perhaps this made it feel easier to address the task in this way. As it was established that the presentation could not be ‘failed’, we reflected as a group whether this meant we ascribed it less importance. I think, if I am honest, this was at times true; however, having this as one of many demands made it seem like a less daunting task. Looking back now I think it has been useful to get used to a climate of working where there are many competing demands on time, and this has encouraged me to develop skills in prioritising and planning. Of course, there isn’t always a ‘good’ time to schedule a task, and this seems true of life in general. Last year I bought a flat, and I was concerned about whether it was the ‘right’ time to do this, with financial pressures and uncertainty about future employment. Would I regret the decision? Also, a friend’s husband was made redundant just before the birth of their
first child, but they just sort of managed and got on with things as best they could. The point I am making is that in clinical psychology work, as with life in general, things do not go according to plan and there are always competing pressures. However, finding a robust way of managing this is a vital skill for life as well as work.

The presentation

During the presentation there were some technical difficulties with playing a video. Unfortunately this was something that had occurred in our first year presentation too. As a group, we reflected that we hadn’t really talked about this. I think it made people feel anxious that we might be penalised, which seemed to evoke a sort of unspoken anger, as people felt that technical hitches often occur in lectures and are just ‘one of those things’ that you have to try and manage as best you can. I wondered about my own negative feeling about being penalised for a technology problem, and it made me think about what it means to have a plan that goes wrong in clinical practice. I have frequently had the experience where I have carefully planned a therapy session, and feel prepared and confident, only to find at the beginning of the meeting that something has happened to the client during the week that means their needs are very different at that moment than I had anticipated. Whilst I try to respond to what the client brings with them into the room, I am aware that I have an anxiety about ‘deviating from the plan’ and on reflection, I think this might be because as trainees we are continuously assessed for our abilities to meet certain standards. As a result, I feel anxious about going ‘off-piste’ even if that is what is required, as I am worried I might somehow be ‘doing it wrong.’ Developing my skills of clinical judgment and trusting them is a topic that frequently comes up in
supervision, and I feel that even by being aware of this tension, I have taken a step towards addressing this.

The issue of being constantly assessed and the anxiety this can provoke also makes me mindful of how it might feel to be in a client’s position when undertaking, for example, neuropsychological testing. This has made me appreciate the importance of trying to put clients at ease as far as possible and to remove the ‘exam’ type feeling from such a situation.

My absence

One thing that I have reflected on a great deal is the fact that I was on annual leave during the presentation itself. This was something I worried about, as I was concerned that the rest of the group might be resentful that I was somehow ‘getting out’ of doing the work. I tried to address this by explaining at the beginning of the year that I would be away. Interestingly, I think that I made even more effort to contribute to tasks than I might have otherwise done in order to assuage my feelings of inadequacy about not taking part on the day. I was also aware that I wanted to give the group a message that I was still very much part of the experience and wanted to support them as much as possible, as the relationships that we have built in the group have become important to me. I think it was my concern about my absence that led to the idea of making a video of my contribution to add to the presentation. I hoped to be present even in my absence!

The idea of absence has also been important on placement. One particular client proved quite elusive during my initial attempts to contact him, and initially was
reluctant to engage with me. I think we managed to build a good therapeutic relationship, but I did notice that it was very difficult to re-engage with him after a period of leave I took over Christmas. I wondered about why this might be. I think partly he was ambivalent about our meetings anyway, and I had discussed in supervision how he might be in the contemplation stage of the cycle of change (Prochaska, DiClimente & Norcross, 1992), but I also wonder if there might also be a psychodynamic perspective on this. I am currently exploring some aspects of the client’s early family relationships in more detail, and I have a hypothesis that looking at his attachment style in more depth may shed some light on his reactions to absence. It has been pointed out that counter transference issues can be important here, (Schafer 2002), and I am mindful of what my own feelings were when re-engaging with him, and how I feel about his apparent continued ambivalence. I plan to discuss this further in coming supervision sessions.
References


Tuckman, B. 1965. Developmental sequence in small groups. *Psychological bulletin,*
63, 384-399.
Personal and Professional Learning and Development Group (PPLDG) work:

*Summary of PPLDG Process Account 1*
My experiences of the PPDLG group over the year have been rewarding and challenging. The variety of tasks we have engaged with, from the problem-based-learning exercises to discussions around placement issues; from the exploration of academic papers to presenting our cultural genograms, have allowed us to settle into a cohesive group. This has not been without its challenges however, and an understanding of group process issues has facilitated the understanding of this further.

For me, experiences within the group are best characterised by describing tensions between different aspects of the group’s work. These tensions include the conflict between the task-orientation of the group, and using it as a space for personal reflection; between my own tendency to be quiet and reserved, and the need to talk and explore together; between ‘doing’ the group ‘right’ or ‘doing’ it ‘wrong,’ and between the temporary and permanent nature of the work in the group as well as in the NHS.

Considering the group over the year has enabled me to track its development as well as my own progress through clinical training. It has highlighted how trainees have contributed to each others’ learning as well as allowing me to see my emerging identity as a clinical psychologist. These themes have allowed us to consider how we might take the group forward into next year in such a way that it can answer our needs to address both personal and professional issues.
Summary of PPLDG Process Account 2
I have chosen to explore the work of the PPD group this year by considering it across 3 levels. Firstly, my experiences as an individual within the group; secondly, the group itself, and finally, in the wider cultural context of working in the NHS.

The PPD group for me has been a very positive experience this year and has really helped my development in training, both professionally and personally. This is largely due to being aware of the genuine warmth and regard of other group members, and I have made links between this and the client experience of person-centred therapy.

The group itself is performing well and has moved on from some of the difficulties of last year. Discussions with the facilitator have allowed the group to create a more positive narrative of itself which has proven beneficial. The groups’ growing confidence and autonomy has also been reflected in the approach to the PBL task, and also in the sharing of knowledge and resources for clinical issues.

An increasing confidence with the complexity of clinical work has been strengthened by the way we discuss our placement experiences, as well as how we consider the wider cultural context of working in the NHS. Discussions around consultation, ethical dilemmas and the perspectives of different professionals have deepened this, which in the current climate of uncertainty around jobs, will hopefully allow us to continue to make a unique contribution as clinical psychologists.
Clinical Section
Overview of all Clinical Experience

Adult Mental Health Placement
This placement was in a Community Mental Health Team.

**Clinical Work:** I worked with both male and female clients, ranging in age from 19 to 65 years old with a range of difficulties including depression, anxiety, post traumatic stress disorder, psychotic symptoms, obsessive-compulsive disorder, bipolar disorder, eating disorders, Asperger's Syndrome and borderline personality disorder. I completed a range of assessments including psychological and pro-forma interviews, questionnaire based assessments, risk assessments and cognitive assessments including the WAIS IV. I was able to develop and consolidate skills in cognitive behavioural therapy, psycho-educational work, and systemically and psychodynamically informed interventions.

**Group Work:** I took part in the STEPPS group for people with a diagnosis of Borderline Personality Disorder and also ran a creative writing group for people who attended the day hospital.

**Service Evaluation:** With trainee colleagues I undertook a research project focussing on staff responses to working with clients with complex trauma.

**Teaching and Presentations:** I presented the findings of the research project with my trainee colleagues in 3 separate Trust locations.
Older Adults Placement

This placement was based in a Community Mental Health Team for older adults and provided services to patients with both psychological and organic health difficulties. Patients were seen in their homes, care homes and day services.

Clinical Work: I worked with patients with a range of difficulties including generalised anxiety, depression, OCD and dementia. I carried out extended assessments and cognitive assessments with both male and female patients who ranged in age from 65 to 82 years of age. I also conducted assessments for a forthcoming mood management group. I used CBT and narrative models of working. I also worked indirectly with staff working in a residential home for people with dementia, and also attended and contributed to some carers’ group meetings.

Presentations: I delivered a presentation to colleagues about how the recovery model might apply to older adults.

Learning Disabilities Placement

This placement was based within the multidisciplinary Community Learning Disabilities Team. I worked with clients who ranged in age from 18 to 62 years.

Clinical Work: I saw patients with a range of presentations including challenging behaviour, depression, anxiety, early signs of dementia and obsessional behaviour. I also worked with people with autism and people who had experienced abuse. I undertook a number of cognitive assessments, neuropsychological tests and risk assessments. I developed and used integrative formulations for working with this
client group, and used psychoeducational, CBT and systemic therapeutic approaches. I also worked indirectly with staff teams and families.

**Teaching and Presentations:** I did a presentation about my developing MRP (focusing on military trauma) to the continuing professional development group.

**Child, Adolescent and Family Placement**

This placement was at a Primary Mental Health Team. Patients ranged in age from 5 to 17 years old.

**Clinical Work:** Patients exhibited a range of difficulties including eating and sleeping difficulties, depression, OCD, cognitive difficulties, school refusal, separation anxiety, challenging behaviour, ADHD-like behaviour, and anxiety. I undertook a number of psychological, cognitive and risk assessments. I was able to consolidate and build upon CBT, systemic and psychodynamically-informed models of therapy. I was also involved in arranging and attending network meetings with teachers, special educational needs coordinators and families.

**Specialist Placement: Interpersonal Psychotherapy**

This placement was based within a CMHT. I worked with 5 clients, ranging in age from 32 to 89, all of whom were suffering from depression. I was able to work with clients within each of the four focus areas of IPT: role transitions, complicated grief, interpersonal sensitivities and role disputes.
Teaching and Presentations: I provided training to my trainee colleagues by conducting (in collaboration with the other IPT trainees) the IPT teaching session for the cohort.
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Service Related Research Project:

*Analysis of complex trauma service needs for an NHS Trust in Southern England.*

*Focusing on vicarious traumatisation in clinicians working with complex trauma and dissociative disorders (Part 3 of a three part analysis).*
Abstract

Complex Trauma is a controversial diagnosis not currently recognised in the DSM IV (American Psychiatric Association, 2000). Dissociative disorders affect areas of awareness, perception and identity and are often a feature of Complex Trauma (Courtois, 2008).

This study aims to identify the number of clients with Complex Trauma with Dissociative Features across an NHS Trust in Southern England, as well as to explore current ways of working with this group, training needs and the impact the work has on staff. These areas were divided across 3 researchers. Strand 3 focuses on ‘Vicarious Traumatisation’ (Dunkley & Whelan, 2006).

An online survey was cascaded from the Field Supervisor to Community Mental Health Teams to identify suitable participants and to collect a baseline of how many Complex Trauma/Dissociative Disorders clients were on current caseloads. 29 semi-structured interviews were conducted with different professionals. A thematic analysis was carried out (Braun & Clarke, 2006).

It was reported that 53.2% of clients with Complex Trauma also had Dissociative Disorders. Staff thought most current treatments are generic and most clients are not appropriately treated. Additionally, all clinicians expressed both a need and a desire for training in all areas. Thirdly, staff reported that whilst working with this group does impact on them, this depends on individuals and tends to be experienced in
terms of feeling inadequate and the pressures on resources. Staff thought that addressing issues such as training and improving supervision might improve clinicians' confidence and skills.

Acknowledgements

I would like to acknowledge the research work and support of the researchers on the other two strands of this project, Gemima Fitzgerald and Mariette Henning-Pugh, in addition to the supervision and guidance of Dr. Fiona Warren and Dr. Maeve Crowley.

Introduction

Complex Trauma (CT) has attracted much controversy. It is not yet recognised within the Diagnostic and Statistical Manual of Mental Disorders (DSM), although it is currently under consideration for inclusion into DSM V in 2013 (American Psychiatric Association, 2000).

There has been a lack of consensus on how to define trauma. Some researchers express concerns over 'conceptual bracket creep' in the area (McNally, 2004) whilst some view it as a concept that helps in understanding patients who present as experiencing Borderline Personality Disorder, in a less pejorative way (Courtois, 2008). Due to this controversy, the way in which services are organised around
catering for this client group has a political dimension, which clinicians may be unaware they are part of.

Complex Trauma has been loosely defined by the APA as enduring interpersonal trauma which has strong elements of disempowerment, loss of control and a lack of the possibility of escape. It is frequently associated with physical, emotional or sexual abuse, torture or domestic violence, and is frequently co-morbid with other disorders resulting in broad treatment needs (van der Kolk & Courtois, 2005; Courtois, 2008).

The APA also lists some possible associated symptoms in DSM IV (American Psychiatric Association, 2000) (See Appendix 1).

Dissociative symptoms are often features of CT yet are often misinterpreted or viewed by clinicians as malingering (Courtois, 2008). They are frequently reported by people who have experienced CT and can occur where psychological trauma or neglect disrupts the developmental period (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005). 5 Dissociative Disorders have been identified, each of which can affect functioning in perception, awareness and identity (See Appendix 1).

It has been suggested that many clinicians feel CT is difficult to treat (International Society for Study of Dissociation, 2005), although this would seem partly due to the confusion around diagnosis and subsequently treatment aims. It has also been
identified that working with clients suffering from trauma can trigger reactions in the clinician similar to the feelings of the client (Dunkley & Whelan, 2006). This is known as Vicarious Traumatisation (VT). Research has identified some protective factors which can minimise this risk. These include preventing isolation, (both personal and professional), developing self-awareness, active optimism and self-care, maintaining clear boundaries, professional satisfaction and meaning making (Harrison & Westwood, 2009).

Considering the high levels of stress and burnout reported amongst clinical staff, (van der Klink, Blonk, Schene, & van Dijk, 2001) this area appears important for effective service delivery. Clinicians’ experience of VT may highlight specific training and support needs as well as the requirement for a greater understanding of the demands of this type of work in CMHTs.

*Current Service in a Trust in Southern England*

There is limited provision for clients with CT with DD features within the Trust. (M.Crowley, personal communication, May 2011). Since October 2010 there has been a CT Specialist Service which currently has the capacity for 4 or 5 intervention sessions per week. Treatment offered usually involves a weekly 90-minute session including approaches such as Psychodynamic Therapy, Dialectical Behaviour Therapy, Cognitive Behavioural Therapy, or Eye Movement Desensitisation and Reprocessing, in addition to medication. Other than this clients are usually treated
within CMHTs but often their dissociative issues are not addressed. (M. Crowley, personal communication, May 2011)

Method

This study aimed to conduct a needs analysis for clients with CT with DD features and the staff who work with them, across the Trust. It investigated numbers of clients clinicians had on their caseloads, the current provision of treatment, staff perception of training needs and the impact that working with this group might have on staff.

These areas have been divided into three strands amongst the research team. Strand 1 focuses on identifying and assessing clients, and also current treatment provision. Strand 2 investigates participants’ perceived training needs (strands 1 and 2 are being reported separately). This strand focuses on the impact on staff of working with this client group and addresses the question: What is the extent and nature of stress and VT amongst staff working with CT/DD clients in this Trust?

Procedure

An introductory email was sent out to CMHTs in the Trust (via the Field Supervisor) outlining the rationale and objectives of the study. Attached to the email was an online questionnaire orienting clinicians with different levels of knowledge to the client group using questions based on the Dissociative Experiences Scale (Bernstein Carlson, & Putnam, 1993) (see Appendix 2).
Interviews

Following this and where consent had been indicated, semi-structured interviews (by phone or in person) lasting approximately half an hour each commenced (See Appendix 3). Interview questions were developed in consultation with University and Field Supervisors. Interviews were not recorded and therefore not formally transcribed because of concerns about clinicians feeling vulnerable and less free to be open in their responses. However, detailed notes were taken as were some direct quotations. After interviewing, strand-relevant data was extracted through the process of thematic analysis. (Braun and Clarke, 2006).

Ethical Considerations

The British Psychological Society (2009) code of ethics was adhered to. The Field Supervisor confirmed that it was not necessary to seek National Research Ethics Service approval. Participants were given information regarding the nature and purpose of the study and were debriefed and reminded that they could withdraw at any time.

Data sources

Appropriate teams for sampling were identified by the Field Supervisor. The sample was clinicians in Adult Mental Health Teams working with clients with Complex Trauma and Dissociative Spectrum Disorders. In total, 39 online questionnaires were
completed and 23 interviews were conducted. 11 of these were in person and 12 were by telephone.

Process of analysis

Analysis was conducted according to the six-stage methodology (Braun and Clarke, 2006). Interviews were initially coded individually, after which they were shared with the other researchers to ensure consistency, coherence and investigator triangulation (Bannister, Burman, Parker, Taylor, & Tindall, 2005). Data was cross-referenced between strands in order to enrich the analysis and develop implications for the Service.

Super-codes emerged within each strand. For this strand, this lead to 4 interrelated themes: 1. The impact of feeling inadequate; 2. Anxiety over case management and risk; 3. 'You just have to deal with it' – Getting the job done whatever your personal response and 4. Grounding yourself – what would make it better? A thematic map was generated (Appendix 4) to ascertain the relationship between themes and subthemes and to ensure they accurately represented all data. They were also checked against the initial codes.
Results

Interviewees identified that they had 94 clients with Complex Trauma and 50 with Dissociative Disorders. Therefore it was felt that 53.2% of clients with Complex Trauma also had Dissociative Disorders.

A clear trend in the study was that whilst working with clients with CT with DD features had a strong impact on staff, this was often not overtly in the form of vicarious traumatisation as outlined earlier (Dunkley & Whelan, 2006), but more in terms of feeling inadequately trained or supported. Although some staff did mention that at times the nature of their clients’ cases had an emotional impact, this occurred far less than people mentioning that anxiety was related to more practical issues, although this may be due to concerns over revealing emotional issues.

Cross-referencing to the data from strand 1 (which focused on current treatment) suggested that those that did not consider treatments to be inappropriate were based in Trust areas where there was more experience of this type of work. Strand 2 data revealed a need for training for all staff across the CT/DD area as most people felt that a lack of training negatively affected their ability to cope with the work.

*Themes in Strand 3:* What is the extent and nature of stress and VT amongst staff working with CT/DD clients in this Trust?

1. 'Flying by the seat of my pants:' The impact of feeling inadequate
Staff often felt inadequately equipped to work with CT or DD clients. This appeared to fall into two areas. Firstly, that the service offered to clients was inadequate:

‘One session of CBT every other week at best just isn’t going to cut it...what happens after? They just get dropped.’ (participant (p) 19)

Secondly, some clinicians felt personally inadequate in their roles.

‘I don’t know what to do with them, it’s just fire fighting...we have a vague sense of what they need but no specifics.’ (p25)

2. ‘Where are we going and what happens if we don’t get there’? Anxiety over case management and risk

A second theme was that there is no clear goal for working with CT or DD clients, although this differed across professional groupings, perhaps reflecting differences in the role expectations of different team members.

‘We’re just trying to hold them together’ (p19) ‘I don’t know what I’m doing.’ (p5).
Almost all interviewees mentioned feeling anxious around how risk is managed.

'I feel more negative effects from being very concerned about risk issues...I feel I need to cover my back....' (p19)

Staff often felt they would be unsupported if things went wrong and that this prevented them from engaging clients fully.

'The Trust has a blame culture... we are very reluctant to take positive risks'. (p19)

It was often felt that it was not helpful that people had no choice but to manage difficult clients alone:

'People can be affected if they are working in isolation... stress, burnout, rigid thinking, proneness to errors of judgment...'

This exaggerated their personal responses to already tightly stretched caseload capacity.
3. ‘You just have to deal with it’ (p19) – Getting the job done whatever your personal response

There was wide variation amongst interviewees around the level of specifically emotional impact of working with CT/DD clients. Often people described situations with colleagues which illustrated the variety of responses they had seen (such as people developing a ‘dark’ sense of humour or reporting feeling tearful after seeing CT clients). It was noticeable that people were keener to share examples from their colleagues’ experiences than from their own, suggesting a reluctance to discuss any personal issues that the clinical work may have provoked.

Some staff seemed to feel that being emotionally affected was an inevitable part of the job:

‘I think about them outside of work more... but no training or supervision would stop that’ (p2)

However, some participants felt that this affected the types of therapeutic work they would attempt with clients.
‘I have felt traumatised by listening to some of their stories… can make you want to put up a barrier and work with the easier problems.’ (p2)

Other staff appeared to experience significant effects.

‘I had a client who switched in a session… this was very distressing for me, it freaked me out, I nearly crashed my car that day.’ (p33) ‘I feel emotionally battered after spending time with them.’ (p19)

Often, clinicians cited both personal reserves and experience as key factors in managing their emotional reactions.

‘I am able to detach myself outside of work… others can’t’ (p2)...‘Some individuals get under your skin’ (p33)

Some people felt they had heard so much trauma they had become deadened to it, in itself a sign of vicarious traumatisation (Dunkley & Whelan, 2006).

‘You need to harden yourself up as a CPN – we just have to deal with it.’ (p19)
It was almost as if at times this sense of hardening up was viewed as a positive coping strategy.

4. ‘Grounding yourself’: What would make it better?

Clinicians often offered comments on how the impact on them could be minimised. These focused on supervision and training. The frequency and quality of supervision received appeared to vary, with some staff receiving ‘specialist’ supervision from a trauma expert and others receiving minimal supervision.

Many clinicians quoted better training as something that would help minimise negative impact.

‘I feel disempowered due to my lack of training’ (p19)

Many participants felt that working with this group required more time for processing and reflecting after sessions, but that this space was not always available.

‘You need time to ground yourself before and after sessions…very stressful if you’re under pressure.’ (p5)
Discussion

Clinicians identified that 53.2% of the clients they worked with who had CT also had one or more DD. However, as many appeared unclear about how to define either category, it seems likely that some clients may have been missed. The researchers had considered providing criteria to clinicians to facilitate the process of identification but felt that as there is not yet a consensus on definition, it might both be leading to clinicians as well as potentially masking the issue that lack of definition is itself part of the problem of working with this group. Whilst this is a limitation of the study it is part of the challenge of needs assessment work.

Working with CT with DD features does have impact on staff but the way in which this happens varies. Some people feel the nature of their clients' case affects them emotionally whilst others experience minimal impact. It was common for clinicians to report negative impacts in terms of feeling exposed due to a lack of training and consequent perceived lack of competence. These deficits became more apparent when working with CT, but were in fact issues related to their work in general, such as excessive caseloads and the constraints of limited resources. However, it appears that there is something particular about working with CT and DD clients that bring such concerns and anxieties to the fore. These specific features appear to be the way in which clinicians feel unable either in terms of their skills or resources to adequately address clients' needs. This is mainly due to feeling they do not understand fully clients' experiences, do not know what the goal of working with
them should be, and are often anxious about ‘doing something wrong’ and making the client feel worse.

Staff commonly reported feeling isolated and unsatisfied. They are also often worried about the high risk of self-harm and suicide and the responsibility they might feel in such cases. The implications of this type of stress is that clinicians may run the risk of higher levels of burn-out and anxiety outside of working hours, which are key features of VT (Dunkley and Whelan, 2006).

Harrison and Westwood (2009) identified ‘active empathic engagement’ with trauma clients as a protective factor against VT. Although they acknowledge this needs to be further explored it is interesting to note that clinicians often felt unsure about the nature of the therapeutic engagement they should seek to foster with their CT clients, which was often attributed to a lack of clear direction and being afraid of ‘making things worse.’ This was supported by the findings of Strand 1 which suggested that staff felt clients were being treated ‘generically’ and by Strand 2 which reported a clear and immediate need for comprehensive training. Across each strand, the need for a better-defined direction about optimal ways of working with CT and DD clients was identified. The lack of this resonated throughout all interviews conducted.
Limitations

One limitation of the study was the self-selecting nature of the sample; if repeated a wider sample which sought the input from teams both familiar and unfamiliar with the CT/DD client group might be more valid. Secondly, the very fact of looking for VT amongst clinicians may have introduced a bias into the findings. Although it might be expected for staff to experience stress at working with this group, restricting this to identifying signs of VT itself might have missed some nuances in the data. This raises questions around the impact of the term ‘vicarious traumatisation’ in itself. Participants might have felt that admitting to signs of this could make them appear not sufficiently competent at their jobs, which given the current climate of job insecurity makes this a particularly sensitive issue. This may have been reflected by the way in which many interviewees knew of ‘someone else’ who had experienced problems, but rarely admitted it themselves. It might have been more useful to conceptualise this strand of the study in the form of clinicians’ perceptions of and responses to stress, rather than looking particularly for signs of VT.

Service-related implications

Interviewees identified that they had 94 clients with Complex Trauma and 50 with Dissociative Disorders. Almost all clinicians interviewed reported increased stress levels of working with this group, and this was found to be the case across staff groups, suggesting it constitutes a trust-wide problem.
It is planned that feedback from this study will be disseminated to the Trust through a series of presentations to CMHTs that have participated. This will take place in August 2011. It is hoped that this will raise awareness of the extent and nature of the challenges of working with this group and facilitate a discussion around how to address these.

Given the results of strands 1 and 2 which revealed that staff think many clients are neither identified or treated appropriately and that treatments are too generic in nature, as well as a need for training in all areas, it appears that an increase in the provision of Trust-wide clinical guidance, comprehensive training appropriate to the requirements of different professional groups and regular, high-quality supervision from someone experienced in the field, would be the most effective way to minimise the risk of clinicians experiencing aspects of VT as well as improving patient care. The benefits of a well-motivated and supported workforce are clear in terms of decreased burn-out and sick leave as well as increased staff retention rates (van der Klink, Blonk, Schene, & van Dijk, 2001). Consequently, a secondary effect of addressing these issues would be a workforce with increased confidence and ability to manage clients effectively. Clear clinical guidelines in both identification and treatment should be developed and comprehensive training offered to staff, perhaps with the additional resource of having a defined CT/DD point of contact for support, supervision and consultation.
References


Appendix 1: Possible associated symptoms for Complex Trauma and the 5 identified Dissociative Disorders (APA, 2000)

(1) alterations in regulation of affect and impulses (e.g. alternating between rage and affective emptiness)

(2) alterations in attention or consciousness (e.g. pathological dissociation)

(3) alterations in self-perception (e.g. believing oneself to be permanently damaged)

(4) alterations in relations with others (e.g. alternating between enmeshment and isolation from others)

(5) somatisation (e.g. dysfunctions in bodily functioning)

(6) alterations in systems of meaning (e.g. loss of previously sustained spiritual beliefs or loss of purpose in life)

The 5 identified Dissociative Disorders (APA, 2000)

- Depersonalisation Disorder (feeling 'outside' oneself): disruption in perception and consciousness.
- Dissociative Amnesia
- Dissociative Fugue (confusion about real identity)
- Dissociative Identity Disorder (alternation of two or more distinct personality states)
- Dissociative Disorder Not Otherwise Specified (Dissociation not covered by the above categories)
Appendix 2: Initial email sent, acknowledgement email sent and online survey questions

(ii) Initial email sent

Dear Colleague,

Your name has been passed to us by your Team Manager as someone who might be interested in training in the area of complex trauma and dissociative disorders.

On behalf of the Trust, we are doing a region wide, needs analysis to establish clinicians’ views and training needs in this particular area.

*Your* responses are therefore vital in helping us understand what the Trust is doing well in this regard and also what can be done better to improve services in this area.

We are very interested in how the training and support for clinicians can be improved so that the experiences of clients can be enhanced.

We would like to invite you complete a very brief survey in order to register your interest to participate in future training planned on this topic.

The survey is in two parts;

- an initial short online questionnaire (you should be able to complete this in about 5 minutes or less)
• an optional 20-30 minute interview (face to face or by telephone) to obtain a few more details from you – if you agree to this we will contact you on the details you provide in the online questionnaire.

All responses are completely confidential. The results will be used to identify areas of good practice and areas where the Trust needs to improve services in this area.

**To complete the survey, and register your interest in this training, please follow the attached link:**

http://www.fahs.surrey.ac.uk/survey/SussexNHS/

The survey is only available until Friday 1st April 2011, so complete it soon to take this valuable opportunity to have your say about what kind of service you would like in this area and register for the training.

If you require more information please contact any of the research team: Mariette Henning-Pugh (M.Henning-Pugh@surrey.ac.uk); Jane Gilbert (Jane.Gilbert@surrey.ac.uk) or Gemima Fitzgerald (G.Fitzgerald@surrey.ac.uk)

Thank you for taking part

Jane, Mariette and Gemima (Trainee Clinical Psychologists, University of Surrey, )
(ii) Online survey questions

Regional needs analysis of Complex Trauma and Dissociative Disorders

Welcome to a needs analysis survey on Complex Trauma and Dissociative Disorders.

The Trust is constantly looking for new ways to enhance the knowledge and skills of clinicians. We are therefore reviewing the service provision and training needs in this area, on behalf of the Trust, and would value your participation.

This survey will give you an opportunity to confidentially express your opinions in order to help us identify areas where the Trust should target efforts to enhance services and training. By participating you will also have the opportunity to register for a specific training program planned in this topic area.

This online survey comprises a number of short questions that can be completed in about 5 minutes. If you want to, you can also agree to a further short interview by telephone or in person.

A section is included at the end to enable us to check the representativeness of the sample and to compare between different groups in our analyses. You only need to provide your name and telephone number if you choose to participate in the follow up interview. This will be used only to contact you for the interview and the data will not be used to identify any individual responses.
There are a number of opportunities within the questionnaire to provide additional comments; these comments will be included in our analysis of the responses and may be included in any reports. The data will not be used to identify any individuals.

Once you click 'Next' you will be directed to the first section of the survey.

If you have any questions you may contact us by email on M.Henning-Pugh@surrey.ac.uk Jane.Gilbert@surrey.ac.uk or G.Fitzgerald@surrey.ac.uk or by telephone on 01483 689441.

This survey has been approved by the Trust and the University of Surrey.

Thank you for taking part,

Mariette Henning-Pugh, Jane Gilbert and Gemima Fitzgerald
Trainee Clinical Psychologists
Department of Psychology, University of Surrey, Guildford, GU2 7XH, 01483 689441

1. Do you have any clients who....? (Please tick all that apply)

q1_1 You consider to have Complex Trauma

q1_2 You consider to have Dissociative Disorder

q1_3 Find themselves somewhere without knowing how they got there?
q1_4 Report that they are watching themselves do things

q1_5 Report having no memory for some important events in their lives

q1_6 Report having lost time from their day without knowing why

q1_7 Have the experience that people and objects around them are not real

   Report being unsure about whether something really happened or whether they
q1_8  dreamed it

q1_9 None, Not applicable

q2

2. What (if any) interventions do you currently provide for clients with any of the
above experiences?

q3

3. What training do you think might be helpful for you, or anyone else, who works
with clients with the above experiences?
4. What would you say are the main challenges for you, or other clinicians, in working with clients that have these experiences?

5. Please add any questions or comments you may have that relate to this topic.

The next stage of the survey is an optional short interview, in person or by telephone. If you agree to go on to the next stage, we will contact you on the details you provide below. It would be very helpful to be able to ask you a few more specific questions about your clients with the above experiences and also on your own specific training requirements.

We would like to ask you a few more questions on this topic and your training requirements. Would you be willing to participate in an interview of no more than thirty minutes, either by telephone or in person?

Yes, I am willing to participate by telephone
q6_2 Yes, I am willing to do a short interview in person

q6_3 No, I would prefer not to participate in an interview

7. Please add the following details that will be held confidentially by the project team (Your name will be used only to identify you for interview purposes). The information regarding your location, professional group and years of service are required to allow us to map the prevalence of these concerns and the training needs across the trust. All answers will be treated as group level data and no individual responses will be identifiable.

locality

Locality

—

Professional Group

—

Years of practice

—

name
Name

(Only provide if you agree to being interviewed)

contact time

Best contact time/day

(Only provide if you agree to being interviewed)

contact

Contact number

(Only provide if you agree to being interviewed)

email

Email

(Only provide if you agree to being interviewed)

Thank you for taking the time to complete this survey
Data Protection

Data collected in this survey will be held securely. Individual results are confidential. The Trust has agreed not to identify any individuals in reporting results, and to use their best efforts to ensure that no individuals can be identified by implication. All results will be combined into an anonymised total for analysis purposes.

All participants are at liberty to withdraw from the study at any time without needing to justify the decision and without prejudice.

All personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

Exit
(iii) Acknowledgement email sent on completion of online survey

Dear,

Thank you very much for taking time to complete the online survey and also for agreeing to participate in our interview.

Your responses are extremely valuable to how the trust will shape its service in this regard in the future.

We plan to contact you by the end of this week (by Friday the 25\textsuperscript{th} March) by telephone, in order to arrange a time to do the interview with you.

If it is convenient for you we would hope to do the interview with you sometime during next week (by Friday the 1\textsuperscript{st} of April). However if this doesn't suit you we can arrange it for another time that may be better for you.

The interview will be about 30 minutes long and you have the right to withdraw at any time. We will be asking you basic details about the clients you have (such as numbers of clients and how you assess/identify them) with complex trauma or dissociative disorder, any therapeutic/treatment approach with them and the personal impact on you working with these clients. These details will be held confidentially and your personal details will not be linked to your responses in any way.

We look forward to speaking to you very soon. Please feel free to contact any one of us if you have any questions at all in the meanwhile.

Kind Regards
Appendix 3

(i) Interview questions

Participant wishes to be included in a list for the training YES

(details will be made available by Maeve Crowley when available)

Demographics

Participant number _______? (didn't do online survey)____ age _____ gender ___ ___

location ______

Professional group ____ ___ years of service in trust / NHS

• How many clients do you have with Complex Trauma, and how many with what you would consider to have dissociative disorder, or both? (note some of these answers may already be on the online questionnaire)
• How do you currently work with clients in this group?

• In your view, what is the goal of treatment with clients with dissociative disorder?

• What training/additional training do you think would be helpful for you/your colleagues to work with this group?

• What kind of things would you consider to be important in a service designed for this client group? (This could be something already available)

• What is the impact on you of working with these clients professionally/personally?

• How did you feel being part of this needs analysis process?

• Any additional comments?
Participant wishes to be included in a list for the training [YES]

(details will be made available by Maeve Crowley when available)

Demographics

Participant number _____? (didn’t do online survey) _____ age ____56____ gender ____F____

location _____

Professional group ____CPN ___3___ years of service in trust 25 in NHS

Interview Questions

JG1
• *How many clients do you have with Complex Trauma, and how many with what you would consider to have dissociative disorder, or both? (note some of these answers may already be on the online questionnaire)*

• 3 out of a caseload of 27 (CT) – more have had DD in past, or PTSD or unclear what they have suffered from. Also where psychosis overlaps with DD unclear.

• All clients with CT on my caseload have been sexually abused as children. One became the abuser then domestic violence issue. Many BPD aspects to presentation – not sure when one starts and the other stops

• One unifying factor is all have had a very complex history – in assessment the most important thing to focus on is getting a detailed history – take your time. Using a genogram useful. People usually either tell you a lot or they get skittish which is in itself a clue in sensitive areas. Needs to be a process of continuous assessment – CPNs gather info over time, and this is the role of a CPN rather than treating directly.

• Team as a whole not great at picking DD CT up – usually they need to be identified through a psychiatrist and they have different views about diagnosis. Sometimes people end up slipping through the net.

• Also depends on your experience and when you were trained – some CPNs might pick it up and others not, or people don’t get referred to the right places and get missed.
How do you currently work with clients in this group

- CPNs can’t really do therapeutic work – that takes place in psychology. CPN role is more to do with ongoing support or crisis management – we don’t or can’t do exploratory work, more just a holding role and being there.

- We could do more I think – too dangerous though. You need to have dedicated and protected time otherwise you leave yourself and your client open to misunderstanding and they might feel let down.

- Sometimes they get a good service – they usually get a lot of input from different professionals, my role with my CT client is to support and contain her.

In your view, what is the goal of treatment with clients with dissociative disorder?

- Depends on professional group- CPN goal is to support. Overall goal depends on the person – it might be to explore the trauma if the person is able to or do more practical things about dissociation. Depend if the person is psychologically minded.

What training/additional training do you think would be helpful for you/your colleagues to work with this group?
• There is no training! – CPNs just have to get on with it – I think this is shocking. Training should focus on helping staff understand the area and what approaches are beneficial and what aren’t – currently we are offered nothing and it makes people anxious. We need training in how these clients present, where we could refer to, what assessments to do.

• What kind of things would you consider to be important in a service designed for this client group? (This could be something already available)

• More specialised supervision would be good but sometimes it feels like there isn’t time for this really.

• To be honest my first priority would be a specific service for PD clients as a whole as you see more of this. And there is a great overlap. However a specific service would work like a CMHT although having the option of an inpatient stay for 24 hour periods would be useful. Risk could then be managed better. The problem is one of resources as treatment takes years and years.

• What is the impact on you of working with these clients professionally/personally?

• Experience helps in dealing with this.
• Many clinicians are wary of this group and feel they have been traumatised by clients and their stories – sometimes it can be an assault on your senses. Also the risk – CT clients are often acting out and can instil anxiety – I feel like I often come to work with anxiety and I feel like I have to cover my back whilst having to be constantly available – the pressure is more from her than the nature of the trauma.

• You need to harden yourself up to work with trauma – we just have to deal with it. You have to be tough and pragmatic.

• *How did you feel being part of this needs analysis process?*

• *Any additional comments?*

*This very much depends on your role in the team I think*
Appendix 4: Thematic Map

- Supervision
- Training
- Don't know what to do for the best
- Uncomfortable with current service offered
- Flying by the seat of my pants: The impact of feeling inadequate
- Don't currently have skills or knowledge but have to keep going—fear of unknown
- Having to deal with whatever client brings to you, minimal time or resources for
  - Insufficient training and supervision
  - Unsupported by Trust
- Lone working and
- ‘Grounding yourself’: What would make it better?
- ‘Where are we going and what happens if we don’t get there’?
- Anxiety over case management and risk
- You just have to deal with it—Getting the job done whatever your personal response
Appendix 5: Proof of Presentation to the Service (email from field supervisor)

From: ------------------------------------------------------------------------------------------

Sent: 18 August 2011 11:00

To: Fitzgerald G J Miss (PG/R - Psychology); Jane Gilbert (Sussex Partnership Trust); Henning-Pugh Mariette

Subject: Copy of your SRRP

Dear all,

Well done for today!

I do not have a copy of your individual projects despite checking all my files. Can you please send me a copy?

Regards

M------

Time to Change is England's biggest campaign aimed at tackling the stigma and discrimination associated with mental illness. Join ------------------ as a member and pledge your support to end mental health discrimination today.

**********************************************************************************************

This message and any attachments contain confidential and privileged information. If you are not the intended recipient please accept our apologies and delete the email after advising the sender of the error. Please do not disclose copy or distribute information in this e-mail or take any action in reliance on its contents: to do so is strictly prohibited and may be unlawful.
The information contained within it may be subject to public disclosure under the Freedom of Information Act (2000), unless it is legally exempt from disclosure.
Abstract of Qualitative Research Project

Exploring the impact of internet dating on men and their self-views:

'Shopping for love online: 'dodgy chicken', 'naïve scientist', 'expert' or 'au natural.'
A great deal of research has been conducted into the scientific complexities of selecting a partner and falling in love, focusing on areas such as genetic and biochemical factors. It has also widely been found that there are frequent discrepancies between online self-presentations and 'reality'. Whilst research has focused on dater's self-presentations, the effect of internet dating on people's sense of identity has not been extensively researched.

The aim of this study is to explore representations of the self in relation to internet dating through lived experience. The research question is: How do experiences of internet dating impact on views of self in adult heterosexual men?

Four heterosexual men aged between 30 and 40 were interviewed. The questions were developed through discussion and consensus between the researchers and were analysed following the Braun & Clarke (2006) six-stage thematic analysis. Four overarching but interrelated themes were identified: People as commodities; the scientific vs. the natural; becoming an expert and shifting self-perceptions.

Internet dating was sometimes described as 'shopping' for partners, whilst the internet dating process itself was a product where your experience depends on your expectations. Participants also felt like commodities in the process. All four participants perceived internet dating as a more scientific way to meet potential partners. They also appeared to consider romantic connections as random and difficult to predict. Regardless of their overall cynicism regarding the science of selecting a suitable mate, all the participants did appear to employ some quasi-scientific methods to filter potential partners. Participants also viewed their experiences as changing the way they saw themselves.
This research could facilitate a greater dialogue around online dating's strengths and limitations and examine how subjective realities are related to overarching discourses around internet dating operating within wider society.
Major Research Project
Stepping out of line: Constructions of Trauma in the UK Military

by

Jane Gilbert

Submitted for the degree of Doctor of Psychology (Clinical Psychology)

Volume 1
School of Psychology
Faculty of Arts and Human Sciences
University of Surrey
July 2013

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Abstract

Background: Some research on combat-related trauma suggests that Post Traumatic Stress Disorder (PTSD) is socially constructed and mediated by historical, social and political context. PTSD continues to attract controversy, but is often used as a way of understanding combat-related trauma in both military and civilian cultural contexts. However, recent literature suggests that the PTSD label might not be appropriate to represent the variability of expressions of distress in serving and discharged combat personnel. Furthermore, reluctance to seek help amongst this group makes it more difficult to appreciate potential variability in distress responses.

Current study: The current study attempts to build on previous work to understand how trauma is constructed according to context and what this enables and disenables amongst a veteran population.

Methods: Discourse analysis was carried out on the transcripts of two focus groups comprising four male officer veterans and four male non-officer veterans. Discourse analysis was also carried out on a purposive selection of 8 newspaper articles from the Mail, the Telegraph and the Sun from 2000-2012.

Findings and conclusions: Overall, the newspaper sample positions veterans as deserving of treatment for combat-related trauma and locates the problem with lack of treatment on the part of governments and civilians who are compensated for spurious PTSD claims. In contrast, the legitimacy of trauma experience is managed in the focus groups through being constructed as unhelpful to cohesion, not likely to occur in those who are properly trained, not a thing associated with masculinity, and not legitimate unless one has served in a particular conflict or at a certain historical
point. These serve as potential barriers to treatment. Additionally, across the dataset it may be observed that expressions of distress in combat veterans are broader than those specified in PTSD diagnostic criteria.
Acknowledgements

With thanks to Laura Simonds, Pam Reeves, Kate Gleeson and others who have contributed to this research process, whether knowingly or not.
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Introduction

Defining trauma

Trauma is a term and a concept that has meant different things to different people across diverse cultural contexts and at various points in time; it can be argued that it is something that has been and continues to be constructed according to historical, social and political context.

Trauma appears to encompass diverse experiences. A cursory internet search reveals that it is talked about in accounts from people who have been involved in accidents, from refugees and asylum seekers, from mothers who have experienced difficult childbirths and of course, from people in the armed services who have been involved in combat. Given the diversity of experiences that are talked about as ‘trauma,’ it makes it difficult to arrive at a definition that can encompass them all.

I would argue that it is important to focus on how trauma is constructed according to context for two reasons. Firstly, different constructions of trauma serve particular functions in the social world; that is, constructing trauma in a certain way both allows and disallows certain ways of making sense of experience. Secondly, considering the power dynamics within these constructions can help make clearer how people suffering with particular types of psychological distress might best be understood and helped.

The concept of trauma has been subject to alteration and reclassification throughout its history. It appeared in Freud’s work in the guise of ‘traumatic neurosis’ (Wilson, 1994) and it has been argued that it was this that formed the staple understanding of the subject in the medical and psychiatric profession until the end of the Vietnam
The Oxford online dictionary (2013) defines trauma in the following way:

- 1a deeply distressing or disturbing experience: *a personal trauma like the death of a child [mass noun]: many experience the trauma of divorce*
- *[mass noun] emotional shock following a stressful event or a physical injury, which may lead to long-term neurosis: *the event is relived with all the accompanying trauma*
- 2 *[mass noun] Medicine physical injury: *rupture of the diaphragm caused by blunt trauma*

This definition creates the possibility for many different experiences to be classed as ‘distressing or disturbing,’ and the etymology from the Greek word for ‘wound’ also shows how trauma can describe the physical or the psychological domain; trauma is still used to describe physical injury within a medical discourse.

However, as this study is concerned with trauma as a result of taking part in armed conflict, it is important to consider how this context defines trauma. This in itself is unclear, and much contemporary research has focussed on how military distress may or may not be related to the symptoms encapsulated by PTSD (Fear et al, 2010), and whether factors salient prior to military service are important influences. Research has shown that there are many other ways in which distress is conceptualised in the military, for example through excessive use of alcohol (Hotopf et al, 2006). Therefore, the remainder of this introduction section will consider how historical understandings of trauma have influenced contemporary understandings of what trauma might mean in a military context.
Reflexive statement

My own position in the debate influences the research process and the framing of my work. As part of my clinical placements, I have come into contact with some people with a diagnosis of PTSD (both military veteran and civilian) and some who, although experiencing some of the criteria associated with PTSD, do not have the diagnosis. I have observed how these different positions influence both people’s own perceptions of their experiences as well as how others view them and the treatment offered. Also, I have spent some time living and working overseas, and although this was not in a psychological context, I have noticed how concepts related to mental health are perceived in different ways across cultures. This has made me interested in the cultural mediation of any concept. Thirdly, I also spent some time working in government in relation to the Ministry of Defence (MOD). I worked alongside soldiers who had experienced conflict situations, some of whom had responses to this that they described as trauma, and some who had had similar experiences but did not use this word. Considering these experiences, this piece of research is a construction of one possible understanding of how trauma is constructed; there will, of course, be others.

This study is connected to other research carried out by a trainee clinical psychologist two years ago (Reeves, 2011). This research conducted a thematic analysis of how trauma is understood within the UK military, and data from this has been used in the current study. It is important to acknowledge the influence of the previous work, in that the way in which Reeves collected her data will have inevitably influenced what she found, and therefore, the discourse analysis that I am conducting is constrained by the particular conversations in which she took part.
At this stage it is important to place the literature around trauma and post traumatic stress disorder (PTSD) in context and to consider contexts other than military in which a diagnosis of trauma might be used.

The neurologist Charcot was one of the first researchers into trauma. Working at the time when psychiatry as a discipline was undergoing a period of intense development, he thought that psychological trauma was the origin of the mental illness known as 'hysteria.' Charcot argued that this often revealed itself through a form of paralysis often including amnesia, convulsions or sensory loss, which occurred a period of time after a physical trauma was sustained (Ringel & Brandell, 2012). Charcot made the link between the 'hysterical symptoms' and psychological experience, noting that the symptoms often played a dissociative role and were the result of having endured very difficult experiences (van der Kolk, Weisaeth, & van der Hart, 1996).

Freud was influenced by Charcot and studied the concept of psychological trauma throughout his career. However, his views varied significantly at different points. In 1896, he suggested that sexual abuse at a young age by another person was the specific cause of hysteria (Freud, 1896/1962, cited in van der Kolk, Weisaeth, et al., 1996, p. 54). However, Freud later abandoned this 'seduction theory' and remodelled it as related to difficulty in acknowledging sexual or aggressive emotions, rather than as connected to actual abuse. Freud's influence on later understandings of trauma was significant. Bracken (2001) argues that as a result of the strong influence of Freud and psychoanalytic approaches on early classification systems in psychiatry,
symptoms of trauma were viewed as time-limited if there was no other pathology present, and were the result of conflicts originating in formative years. Bracken argues (2001) that this did not take into account the potential of events in adulthood as causing trauma pathology.

*The influence of war on understandings of trauma*

Much research into trauma was carried out on military populations. Arthur Meyers used the term 'soldier's heart' in 1870 (Van der Kolk 1991) to describe what he viewed as primarily the over-arousal of the cardiovascular system after a soldier had been at war. The symptoms he noted included fatigue, palpitations and tremors, and indicated a biological response to the stress of battle (Birmes et al., 2003; Moreau & Zisook, 2002).

The biological explanation meant that the military establishment was not forced to answer uncomfortable questions about the meaning of war itself (Van der Kolk et al 1996). It may also reflect the kind of knowledge (i.e. 'scientific') that was given status and thus privileged at the time.

During the First World War, the term 'shell shock' with its accompanying symptoms of 'crying and silent unresponsiveness' (Lasiuk & Hegadoren, 2006) became a common construction for understanding of the experiences of soldiers in the trenches. The reaction was initially considered due to ruptured blood vessels through experiencing explosions. It has been argued that soldiers with shell shock were viewed as unfit for duty and were sent home (McHugh & Treisman, 2007). This is an example of psychological trauma being related to weakness (Reeves, 2011).
Psychologists screened recruits before deployment to 'check' for the likelihood of developing shell shock (Sammons, 2005). This could have proliferated the idea that there was something substandard in recruits who might be deemed likely to suffer from shell shock, and thus those who were able to go to war automatically became constructed as being strong.

Understandings of shell shock then moved more towards ideas of inherent 'weakness' and even ideas about genetic vulnerability (Van der Kolk, 1991). At this time much work was being carried out into genetic inheritance, with the early work of Gregor Mendel being rediscovered and debated in scientific circles (Bowler, 2003). Ideas about Darwinism were also gaining momentum, lending weight to the idea that if a person suffered traumatic reactions, they must be constitutionally weak and therefore inadequate soldiers (Brunner 2000). Trauma and weakness were again linked.

By the Second World War it was being argued that group factors such as communication and trust were most predictive of the development of psychological problems in soldiers (McHugh & Treisman 2007), which also meant a radical change in the approach to treatment. Rather than being sent home unfit and in disgrace for being cowards, suffering soldiers were instead given periods of rest and recuperation close to the front line. This approach was termed 'forward psychiatry' and included the assumption that the negative emotional reactions associated with war were actually a normal human response to circumstances rather than indicative of any weakness. It was thought that treatment in the conflict zone was better than sending people home; otherwise the protective factor of group cohesion would be removed.
and individual stigmatisation and isolation would be increased. This also legitimised soldiers remaining deployed in the war (as it was actually for their own good), as well as minimising the costs of sending people home and making it more difficult for malingerers to escape the fighting (McHugh & Treisman 2007). Jones et al (2003) note that although positive results were reported of the forward psychiatry approach, personal records kept by psychiatrists suggested a less successful picture. However, they argue that reporting negative results could both damage a doctor’s career and affect morale, perhaps indicating that social forces mediated what could be presented as true.

It has been argued that there was something particular about the political and economic context in the US after the Vietnam War that produced the ‘creation’ of the post traumatic stress disorder (PTSD) diagnosis (McHugh & Treisman, 2007). Lasiuk and Hegadoren (2006) argue that it was this political process rather than empirical research that led to the arrival of PTSD in the 1980 DSM III. They allege this is evidenced in the way that PTSD is narrowly constructed, based only on the experiences of combat veterans and holocaust survivors, both significant groups in US society at the time (Lasiuk & Hegadoren, 2006; Shepherd, 1999), a point to be returned to later.

**Trauma related to abuse**

However, there were other factors which influenced the development of the PTSD construct. Ringel & Brandell (2012) argue that during the 1970s, trauma related to the abuse of women became much more in the public domain, largely as a consequence of the women’s movement. They draw comparisons between the
Vietnam War veterans' groups and women’s consciousness raising groups in the way on which both focussed on achieving validation and support for their suffering, as well as campaigning for social and political change. Russell (1984) conducted research which found that of a random sample of US women, one in four had been raped and one in three had been sexually abused. She asserts that previously most occurrences of abuse had remained hidden and unreported in the home. Herman (1992) comments that studies such as this led onto a more detailed understanding of how to assess and treat domestic violence and its consequences.

**PTSD**

It has been argued that the increasing influence of the survivors of abuse movement and the Vietnam veterans community combined as a result of mental health professionals reporting similar symptoms in their clients (Herman, 1992). This influenced the way in which the PTSD diagnosis was set up in the DSM III; although it addressed some common symptoms following experiences such as combat, rape, domestic violence or child abuse, and established the four clusters of intrusive re-experiencing, avoidance, hyper arousal and hyper vigilance, the diagnosis failed to focus specifically on early antecedents for trauma-related distress, such as abuse or neglect in childhood. It also did not allow for more complex psychosocial explanations (Bracken, 2001).

The existence of the diagnosis of PTSD is controversial, and much has been written about how it came about and problems with its conceptualisation, a point to be returned to later. However, in the last thirty years much research into trauma has
been grounded by an understanding of PTSD, and some public perceptions of trauma have perhaps been influenced by this.

According to the Diagnostic and Statistical Manual IV (Text Revision) (DSM IV-TR), (APA, 2000), a diagnosis of PTSD requires exposure to a traumatic event which has included actual or threatened death or serious injury to the individual or someone else, and where the sufferer's response involves 'intense fear, helplessness or horror.' It also requires sufferers to experience symptoms from three symptom clusters; intrusive recollections, avoidance and hyper-arousal. These symptoms must be present for more than one month and severely impair the sufferer's ability to function in key areas of their life such as work or relationships (APA, 2000).

Although I am focussing on the DSM, as this is the system most widely used in the context I am working and studying, The International Classification of Diseases (ICD) also contributed to understandings of trauma. The ICD has been the international standard diagnostic classification since 1994 and is used by the World Health Organisation. PTSD was first featured in the ICD 9 in 1992, although classifications such as 'adjustment reaction' following exposure to acute stress was included in the 9th edition in 1978. These 'stress reactions' were described as being transient (Turnbull 1998) and could be of any severity and nature. PTSD as a defined disorder appeared in the DSM in 1980, and in the ICD 10 in 1992. Each defines PTSD in largely similar ways. However, there are a few differences. For example, in both someone has to be subjected to a traumatic 'stressor,' but whilst the DSM requires a specific subjective reaction to this, the ICD does not. Also, the exact numbers of symptoms required for diagnosis differ. PTSD in the ICD-10 has not gained the same level of recognition as in the DSM, perhaps because of its wider
mandate as part of the World Health Organisation to focus on all illness, whereas the DSM focuses more specifically on mental disorder.

That the construction of trauma is an ongoing process is also evident from some of the changes to the criteria in DSM V, published in May 2013. The three cluster symptoms described above have been redefined as four symptom clusters; re-experiencing, avoidance, negative cognitions and changes in mood and arousal levels (APA, 2013). Additionally, the criterion requiring fear, horror or helplessness immediately after the stressor event has been removed, and PTSD itself will move into a new classification of trauma and stressor-related disorders rather than anxiety disorders.

The label of PTSD has been applied to other posttraumatic syndromes such as Rape Trauma Syndrome and Child Abuse Trauma, (Courtois, 2008). Research into dissociative disorders and their association with childhood abuse led to the conclusion that people who had experienced chronic trauma did not necessarily have the same psychological problems as those diagnosed with PTSD (Courtois, 2008). Other work makes links between childhood trauma and the later development of psychosis (Goodman et al, 1997, cited in Bentall, 2008). Some evidence seems to support a distinct category for Complex PTSD, (CPTSD) or at least demonstrates the need for a concept to account for experiences not accounted for by PTSD (Courtois, 2008).
The impact of PTSD on understandings of war trauma: The Falklands War, The First Gulf War, 21st century conflicts and current research into trauma and the UK military

According to Shepherd (2000), PTSD as a concept did not become established in Britain until after the Falklands War. He argues that this may have been a deliberate avoidance on the part of the Ministry of Defence. It seems plausible that minimising public perception of military suffering during the Falklands War was pragmatic for the government of the day, given the war's controversial nature.

The role of PTSD in Britain was perhaps complicated by the emergence of what came to be called 'Gulf War Syndrome' after the Gulf War (1990-1). The symptoms of this syndrome were predominantly physical, including headaches, cognitive problems and digestive issues. However, some sufferers were labelled as malingerers and accused of only seeking compensation (Fossey 2010). There is a continuing debate about whether this is the case or whether exposure to toxins during the war could have produced such physical symptoms. Reeves (2011) comments that for veterans, it might be that the idea of being affected by toxins is more comfortable than admitting the experience of psychological distress.

In the last 10 years, there has been more systematic research carried out into veteran health (both physical and mental) than ever before. A large scale study carried out by The Kings Centre for Military Mental Health (a collaboration between the Institute of Psychiatry and the Department of War Studies at Kings College London) in 2006 compared military personnel who had and had not served in the Iraq conflict. It was found that there was no 'syndrome' that had appeared to characterise the
constellation of symptoms reported to have arisen from the Gulf War, and that there was in fact no increase in mental health problems per se except for those soldiers in combat roles who were in the reserves. It was also found that shorter lengths of deployment helped reduce the risk of distress and also that pre-deployment mental health screening and psychological debriefing were ineffective (Hotopf et al, 2006). Some research has controversially suggested that socioeconomic status is related to likelihood of developing trauma, (Schnurr et al, 2004) but it may also be that soldiers from this group have less capacity to cope with adversity and may be more likely to turn to counterproductive coping strategies. Also, it could be argued that if the biggest predictor of PTSD is being in a war, then there is something inevitable about its development in some individuals which cannot necessarily be prevented.

A follow-up study to the 2006 work in 2010 (Fear et al, 2010) found that there were no increases in mental health problems in those who had previously been studied that could be related to their combat experience. The types of problems experienced most were common mental health problems that would be found in the general population, rather than PTSD. The researchers identify a mismatch between the actual problems reported by troops and targeted care; presently most of the current mental health initiatives remain focused on PTSD even though this is not the biggest problem. (Fear et al 2010).

Fear et al (2010) found that there was no association between multiple deployments and mental ill health. The study is based on data from the previous few years, where British forces were stretched by being committed in both Iraq and Afghanistan, and multiple deployments would be more likely. Although Fear et al (2010) acknowledge that there might be a ‘healthy warrior’ effect (where people with poor psychological
health are less likely to be redeployed quickly and therefore those who have experienced multiple deployments in fact are just a more resilient group), the study also says that the lack of association ‘can be viewed as support for the appropriateness of the UK Military’s ‘Harmony’ guidelines, which outline the recommended number of deployments and length of time between deployments for the UK armed forces’ (Fear et al, 2010, p1794). A discourse analyst could view this as a way of presenting reality that potentially legitimises and makes seem logical a particular political position; that it is acceptable to send troops on multiple deployments as there will not be any ill effects on their mental health.

**Critiques of PTSD**

**The Vietnam War and PTSD**

The PTSD diagnosis has been heavily criticised in the following key areas: its relationship with the Vietnam War, sociological arguments which suggest the diagnosis is in some way a reaction to the postmodern world, anthropological arguments which criticise it for being western-centric and potentially damaging when applied in other contexts, criticisms that it unhelpfully pathologises normal human reactions to distress, and instability in the way in which it is defined in the DSM. It has also been criticised in terms of how it is linked with economic concerns about compensation. I will look at these criticisms now in turn.

Herman (1992) argues that the advent of feminism in the 1970s allowed the consideration of the impact of the trauma of rape, and similarly, the widespread anti-Vietnam War pressure movement offered an alternative way of looking at war. Previously the propaganda message delivered had been that war was associated with
individual glory, and was a positive thing. Bracken (2001) argues that because there was a social context for viewing the Vietnam War as negative, this enabled psychiatry to take seriously the psychological problems of veterans, and that PTSD was the socially constructed result of this process.

It has been argued that on returning from war, US soldiers found themselves labelled negatively for alleged atrocities against Vietnamese people. Some were called 'babykiller' or 'psychopath,' and this public reception could have been influential in the instances of distress and antisocial behaviour which followed (Summerfield, 2001). Psychiatrists diagnosed veterans with depression, anxiety, personality disorder or schizophrenia. This meant that the new diagnosis of PTSD was also criticized for being unnecessary, as it was argued that the experiences of trauma sufferers were already covered by combinations of other disorders (McNally, 2003).

**PTSD as a reaction to the post-modern world**

Bracken argues that PTSD is related to something peculiarly associated with life in contemporary post-modern societies. (Bracken, 2001). Herman (1992) considers the 'social trauma' of world events such as war, arguing that there is a pattern requiring traumas to be removed from social consciousness as well as from individual consciousness. She argues that a secure social context is required for an individual to hold a traumatic event in consciousness, and for society to hold an event in its collective consciousness similarly requires the context of containing social and political institutions. Trauma researchers have identified a key symptom of PTSD being a loss of meaningfulness, leading to people being unable to integrate the
meaning of the traumatic event into their other experiences, which consequently produces distress. Bracken (2001) argues that there is something about the post modern world which threatens the institutions and structures, such as the church, which have given people the means by which to understand things like death and loss and consequently create this sense of meaning. Also, shifts in the economic order have meant that the priority has become consumption rather than production, and that the result of this is the ongoing creation of new needs and desires to satisfy. This extends to what Bracken calls an ‘expert discourse’ (Bracken, 2001, p740). This includes psychology, and has led to the idea of the ‘traumatised individual’ seeking psychological ‘help’ from ‘experts’ for personal problems. Bracken goes on to argue that these social conditions may be related to the increasing ‘popularity’ of PTSD as a diagnosis; it captures this sense of a loss of meaning, and in some way reflects Western society’s need to contain and categorise the negative life events previously given meaning by their place within a more predictable and organised social world (Bracken 2001).

However, this critique is something of a generalisation that the modern and postmodern worlds are discrete things, and Bracken does not take into account the likely variability between how able people were at different points in history to ascribe meaning to events via robust social institutions. It also does not discriminate between when people may be experiencing significant problems as a result of a horrible experience, or where they may be suffering more from existential angst. However, it makes sense to question the overtly cognitivist and applied science model within which PTSD is located, which is often presented as being ‘true.’
Cross-cultural applicability

The PTSD diagnosis has also been criticised for being Western-centric (Bracken, 2001, Summerfield, 1995, Young, 1995). Young, a medical anthropologist, encapsulates this by criticising PTSD as being 'glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources' (Young, 1995, p5). Summerfield (1995) suggests that PTSD cannot automatically be applied in non-Western cultures due to the way in which it reflects western concepts and cultural organisation. This is particularly important in terms of how it assumes distress 'happens' in the mind of an individual. He also asserts that the meaning attributed to different trauma 'symptoms' is variable across cultures, for example nightmares depicting a traumatic event might be a problem for one person but not another (Summerfield, 1995).

Summerfield studied war displaced people in Nicaragua. Although he found that symptoms of PTSD were observable, he noticed that this was not something that the people themselves paid much attention to, instead focussing more on somatic problems. He also did not identify these people with being 'psychiatric casualties' (Summerfield, 1995, p1), instead commenting that they were managing as well as could be expected given the likelihood of being attacked. Interestingly, he points out that in this context, a PTSD symptom such as hyper vigilance could be valuable rather than problematic, as it might save lives.
Pathologising ‘normal’ human reactions

Another criticism of PTSD is that it unhelpfully pathologises normal responses to traumatic events (Burstow, 2005). Burstow argues that flashbacks and nightmares are in fact an essential part of processing trauma, that PTSD does not take into account the social context of the ‘traumatised’ person, and that it might be expected that someone might not have ‘recovered’ from a traumatic event one month afterwards. She criticises the DSM for suggesting that if this is the case there must be something wrong with the victim. Burstow argues that this makes the diagnosis potentially damaging, particularly if clinicians try to eradicate these symptoms which actually have a psychological purpose. (Burstow, 2005). She also asserts that the idea of the world being a ‘safe place’ is inherently false and that to classify people who are for example, hyper vigilant to threat as having a disorder, is part of a white, western, patriarch-dominated model of society.

Torture

Summerfield (1995) argues that how a person ascribes meaning to an event is the most important aspect of how they will respond to trauma. This is supported by work focusing on people who have been victims of torture. Patel (2011) argues that it is a mistake to assume that the model of PTSD can predict how people might integrate their experience of torture with other traumatic experiences. In the west, torture might be conceptualised as a violation of personal integrity, but it does not necessarily follow that it is viewed in the same way cross-culturally (Patel, 2011; Summerfield, 1995). In cultures where more importance is placed on the community
and the family, an individual's experience may be considered less important than the collective, no matter what they have experienced. The PTSD diagnosis privileges the inner world of the individual, and thus cannot account for these wider collective factors. Summerfield (1995) notes that torture is itself contextual and rarely happens in isolation, instead destroying whole communities. This could mean that the destruction of families is the key meaning attributed to the torture, rather than more individual experiences which may or may not align with the symptoms of PTSD. Summerfield cites the example of women in the Philippines raped by soldiers; they became prostitutes in order to survive, as their rural communities no longer accepted them. Their trauma, then, is as much connected to this rejection as to the original event. Similarly perhaps, torture may not be what its victims report as the worst thing they have experienced (Summerfield, 1995). This weakens the case for providing services such as refugee counselling in western countries within a PTSD framework. Instead, Summerfield argues, any intervention must be conceptualised as part of a wider human rights framework, focussing as much on practical concerns such as housing.

**Changes in the DSM**

Further criticisms of PTSD focus on the way in which PTSD's symptom definitions have changed over different iterations of the DSM. For example, PTSD's criterion A requires there to have been a 'stressor' event before a diagnosis can be given. The definition of this was broadened in DSM IV to include people who were not themselves directly exposed to the stressor but who heard about it from someone else, leading to people who had watched a frightening Halloween TV programme or
losing cattle to foot and mouth disease attracting a PTSD diagnosis (Summerfield, 2001). McNally (2003) considers the differences between being in a war and hearing about being in a war, and argues that the latter must be 'qualitatively distinct from being subjected to military bombardment for days on end while huddled in a muddy trench' (p231). He argues that such diversity of experiences makes it impossible for there to be a single underlying psychobiological mechanism that can account for them all. McNally (2003) cites work by other researchers who have argued that something like overhearing sexually explicit jokes in the workplace can be viewed as a traumatic stressor, and criticizes this as something related to the gaining of litigation compensation. These continuing debates seems to call into question how helpful PTSD is a as a category aiming to classify, as clinicians and academics still fail to reach a consensus on definition and what were once considered key aspects of a PTSD diagnosis (such as the requirement to experience a particular subjective reaction to the 'stressor' event) are now discredited. This further emphasises how trauma is inseparable from the context, as well as how much it remains a contested concept.

Malingering

One of the key criticisms of PTSD in the Western world is the scope for people to be 'malingering' their symptoms in order to gain financial rewards. This criticism has been levelled particularly at Vietnam veterans (McNally, 2003). It is easy to see why, with the prospect of a substantial yearly payout, that veterans would find it difficult to say if their symptoms had disappeared, as this would been significant financial losses. This is also an issue in the civilian world, where people may receive
compensation for accidents. There have been some identified cases of outright fraud in relation to this. For example, Burkett & Whitley (1998), found that some Vietnam ‘veterans’ had never even served in that conflict, or in some cases even been in the military, yet were still receiving compensation. These researchers also claim that many studies of combat related PTSD, particularly in the US, are obscured by including people who may have lied about the nature of their combat experiences. This means that the research findings that our knowledge of PTSD is based on may well be questionable.

*Men’s help seeking patterns*

As constructions of trauma have changed over time, so have attitudes towards help seeking for mental health problems. Shepherd (2000) considers sociological change to be responsible for the loss of the ‘stiff upper lip’ approach to mental distress, which was a dominant discourse during the Second World War, to the current context where there is more of a focus on talking about difficult feelings. In this way, culture and context constrain what is possible in terms of seeking help. As this study is focusing on a male military population, a group which has its own culture and where there is a reluctance to seek help for distress, it is important to consider what is known about how men access help in general and how military culture might mediate this.

It could be argued that the military represents a distinctive culture in itself, with its own ideology and practices. It has been identified that within this ‘culture’ there is a dominant discourse that centres on physical and mental resilience and fitness, and where being seen to experience distress represents a weakness (Langston et al, 2010).
It has also been suggested that characteristics such as toughness or resilience are positioned in opposition to those associated with mental health, which is viewed as being ‘feminine’ and centred on discussion (Kilshaw, 2008). This may impact on how able soldiers feel to access help. It could also be argued that mental health services exclude certain groups, for example, men, by not adequately challenging such discourses.

The concept of hegemonic masculinity proposes that men are expected to conform to an idealised form of ‘maleness’ in order to remain dominant (Connell, 1995). In order to claim an idealised masculinity, men must be strong and refuse to acknowledge personal pain which could be viewed as weakness (Kaufman, 1994). This also enables them to maintain identities associated with power and privilege (Courtenay, 2000). It has also been argued that social norms of traditional masculinity can lead to the inhibition of expressing emotion (Moller-Leimkuhler, 2002). Consequently, for most men, the idea of asking for professional help is associated with stigma. This appears to be true for a military population.

It has been found that men are less likely than women to seek help for physical and emotional problems. Research shows that men are less likely than women to label feelings of distress as ‘emotional problems,’ irrespective of age, social background or ethnicity (Addis and Mahalik, 2003). O’Brien et al, (2005) argue cultural messages received about the importance of being tough, controlled and self reliant conflict with the processes associated with seeking help, such as relying on others or being emotionally uncontained. This could be relevant to a consideration of the role of a successful soldier which is constructed as highly masculine. Male ideologies can be
very powerful in influencing what members of a particular culture understand as being 'normal.' As there is evidence that cohesion is a key part of being a successful soldier (Fear et al, 2010), challenging such homogenised masculine roles is very difficult.

Green et al (2010) argue that the military context means that caring behaviour is based on the strong bonds between soldiers and that this 'looks like' the camaraderie and banter that is identified by them as a feature of army life. This research acknowledges a contradiction regarding the existence and tolerance of emotional distress within the army; there is something about being in a cohesive unit that actually supports people suffering from distress, whilst, at the same time, this cohesion also promotes an attitude of intolerance towards people who do not fit into its confines which affects people's perceived capacity to seek help.

Research has also shown that the degree to which a problem is viewed as being 'normative' influences help seeking behaviour (Addis and Mahalik, 2003). This is important considering the relative difficulty veterans have in acknowledging distress of any kind within their peer group. The fact that the focus groups in this study were also in peer groups (see method section) may have strengthened the effect of this. This could mean that, as trauma is not observed much, it is considered non-normative. This is related to the idea that the reactions of others are key to the decision about whether to seek help (Wills & DePaulo, 1991); in a military context where peers may align with a construction of help seeking associated with weakness, this could be influential.

It has been found that men are less likely to seek help if the 'problem' is 'ego central' (Wills & DePaulo, 1991), i.e. related to a quality that the individual perceives as
important. Addis & Mahalik (2003) use an example to illustrate this, where a man who conforms to the idea of emotional stoicism feels that seeking help for depression threatens his self esteem, but, if he does so, he constructs his choice as one related to 'taking control' of the problem. This then serves to support the norm of emotional stoicism whilst also constructing masculinity as something that requires one to be decisive and authoritative, even with oneself.

It has been found that the symptoms of male depression include self-destructive behaviours, such as physical and sexual risk taking, over working, social isolation, anger and substance misuse (Kilmartin, 2005). It has been suggested that female depression 'looks' very different, but that male presentations of depression which include the above symptoms are not recognised as indicative of depression and therefore not treated as such (Kilmartin, 2005). Therefore, many men are not being understood and treated appropriately. Again, this is very relevant for military expressions of distress, particularly when it does not align with established mental health labels.

One current approach to addressing mental health concerns during deployment is 'TRiM' (Trauma Risk Management) (MOD, 2013) an MOD-endorsed model of peer management for potentially traumatic reactions where those exposed to events that may invoke a trauma response are peer monitored and support and education is provided as and when required. It aims to not pathologise a 'normal' reaction to traumatic events, but to identify at an early stage those who are not coping. Research has shown that the use of TRiM was associated with self-reported increased psychological resilience within Royal Marine units, and also that it may have assisted in reducing stigma associated with trauma as a result of the emphasis on peer support.
(Frappell-Cooke et al, 2010). However, the researchers acknowledge that this does not account for possible group factors in particular units that may make help-seeking more or less easy or appropriate.

**Research question**

Currently, we know that a small percentage of veterans are diagnosed with PTSD and access treatment, but many others experience other mental health problems, and it is not clear how the impact of active combat may be mediating this. This means that our current understanding of military trauma potentially misses the experiences of many people who would not necessarily describe their experiences within a PTSD symptom framework, possibly complicated by a reluctance to ask for help, and the fact that this framework itself remains contested emphasises the instability of the concept.

This study aims to investigate how trauma is constructed both in a veteran population and also within wider society, operationalised via newspaper accounts, and how this might align with or depart from the PTSD construction. This additional context is important to contextualise discourses available in society which may impact on veterans' subjective experiences. Using a discourse analysis approach can contribute to new understandings in this area, as rather than only facilitating a consideration of what is constructed, it will promote our understanding of what the function might be of constructing trauma in this way, and the social forces that might influence this process. The research question is: How is trauma constructed within UK military veterans and how is this related to wider cultural constructions of trauma?
Method

Discourse Analysis

Discourse can be understood as ‘systems of meaning’ that are ‘related to the interactional and wider socio-cultural context and operate regardless of the speaker’s intentions.’ (Willig, 2008, p147). From this perspective, any reality is constructed in language; it also requires anybody analysing discourse to ‘read’ the context in order to understand the specific set of circumstances that led to that piece of discourse being selected by the speaker or writer, and not another.

The fundamental principle of discourse analysis is that people construct their realities through talk and language, and the way in which discourse is used privileges and denies certain versions of what is real. These ideas stem from the 1970s intellectual movement labelled as post-structuralism. An important aspect of poststructuralist thinking that informs the process of discourse analysis is the need to consider the variety of perspectives in understanding and interpreting any text or piece of discourse, even if there is conflict between these interpretations (Parker, 1992). In addition to this, understanding how the meaning of a text can change in relation to the identity of the observer or researcher is a key part of understanding how the nature of discourse creates different versions of reality.

As Potter & Wetherell comment, in discourse analysis, ‘there is no analytic method’ (Potter and Wetherell, 1987 p169). Different researchers have placed different emphasis on what are the most salient aspects of a discourse on which to focus. Parker (1992) identifies seven criteria to consider when working with discourses. These are that a discourse is realised in texts, is about objects, contains subjects, is a coherent system of meanings, refers to other discourses, reflects on its own way of
speaking, and is historically located. Additionally, there are three important 'auxiliary' criteria, which are that discourses support institutions, reproduce power relations and have ideological effects (Parker, 1992). These considerations move more towards Foucauldian discourse analysis (see below) which is adopted for this study. Despite Potter & Wetherell’s comment, the process I have followed is in accordance with Willig’s (2003) six stage methodology. I have used this approach as it appears to address the concerns raised by Parker (1992) in the form of encouraging the researcher to interrogate their data across these key domains.

_Foucauldian Discourse Analysis (FDA)_

This study employs Foucauldian discourse analysis (FDA), based on the work of Michel Foucault, a French philosopher whose work addressed the relationship between power and knowledge, and how these might be related to social control through the institutional use of power, maintained by societies. These are clearly issues relevant to the history of mental health and how those experiencing mental health problems have come to be understood and positioned in society.

FDA considers the relationships between discourse and institutions, and how this affects the distribution of patterns of power within society (Willig, 2003). It also seeks to describe and critique how people’s realities are constructed through discourse, and the effect this could have on their experiences. As such, it explores the distribution of patterns of power within society. Institutional practices are constructed through the use of discourse, and such discourses can allow the legitimisation and maintenance of the status quo. For this study, an individual’s
claim to any experience of trauma is mediated by the social and political forces which shape the culturally available meanings of the concept at a particular time and context. FDA allows an exploration of how this might be achieved through language, and the implications this has for experience.

This study: Literature Review
The literature search was conducted using the databases Psych Info and Psych Articles. There were no date parameters used as it was important to access a wide picture of research in this area. The core concepts of the UK military (armed services, army), trauma (mental health, psychological trauma and PTSD) and then history were used in all their combinations. Only English language articles were included. Papers were excluded if they dealt with issues not exclusively relevant to trauma, or trauma in the UK military. The remaining articles were classified chronologically in order to give a sense of the progression of thinking around the topic.

Focus Groups
I have chosen to use archival data for this study. This data was collected by a previous trainee clinical psychologist (Reeves, 2011). Although Reeves conducted a thematic analysis on the focus group data, it was felt that it would be useful to take a discourse analytic approach to further explore the possible social or political constraints that might be impacting on constructions of trauma and provide fuller contextualisation. It could be argued that it was more ethical to fully use this existing data than to collect more. As I was not involved with interviewing veterans for the
newspaper articles, the use of archival focus group data is consistent with this, and ensures parity across the data sources.

One key element of research into military mental health is the impact that being part of an ‘army group’ has on individual perceptions of distress and wellbeing. For this reason, Reeves decided to conduct focus groups, in an attempt to recreate intragroup processes that might facilitate an exploration of the role of cohesion. This could also be related to how able soldiers felt to seek help, as reactions of an individual’s peer group have been argued to mediate this (Goldberg & Huxley, 1980)

The groups were divided into officer and non-officer groups. This was in order to explore if there were differences in understandings of trauma or perceptions of stigma in these groups. Additionally, the possibility of command hierarchy unduly impacting on what could be said was removed by separating officer and non-officer participants.

Reeves did not set an age limit for the focus groups, largely because it is thought that trauma can affect veterans at various points after leaving the army. Personal experience of trauma was not a requirement for the focus groups, although it is acknowledged that this would be relevant to what veterans brought to the groups. The age range of the groups was between 44 and 71. The serving years covered were from 1957 to 2007.

Questions asked covered three main areas: exploring what trauma is, perceptions of the traumatised and help-seeking in the military. The researcher explained that these questions would be used flexibly in order to allow the natural development of the conversations. The data collected was inevitably influenced by her. She decided to
only recruit veterans as there were some organisational barriers to recruiting currently serving soldiers. The latter group also might have found it difficult to express views about psychological distress in the context of being currently employed by the army. Examples of the information sheets and consent forms provided to participants as well as ethical approval can be found in Appendix 1.

The focus groups were transcribed and it was these transcriptions used in order to conduct a discourse analysis for this study. These transcripts were read and re-read several times, and instances of constructions of trauma were identified and isolated (see Appendix 2). Discourse analysis was then carried out in accordance with Willig's six stages (Willig, 2008).

**Newspaper articles**

In addition to the focus groups, it was also decided to examine further resources related to constructions of military trauma. This decision was taken largely because of the importance of context in understanding how people deploy linguistic resources to advocate certain versions of reality. For this reason, it was thought that the two data sources would complement each other in terms of the possible power relations being deployed in each.

A discourse analysis view of the world considers the person as constructed by and through discourse in the social world. In Foucauldian terms, it is the social world which mediates the 'reality' as experienced by individuals. If this assumption is made, then it follows that it while it is useful to consider something from an intrapersonal and interpersonal perspective, it is also important to view it from the perspective of wider culture and society. As discussed earlier, discourse analysis aims to analyse how the social world is constructed through language, and the power
dynamics that are part of this. The analysis seeks to explore how discourse mediates how a person might view the world, and their relationships with institutions and ideology.

In keeping with social constructionist approaches of which discourse analysis is a part, it makes sense that a veteran’s perception of trauma will be mediated by his own experience but also by the culture in which he lives and the discourses available within it. For this reason, it seemed important to look at discourses around trauma that exist in a cultural context.

Of course, there are many data sources that might be analysed in an exploration of how military trauma is constructed at a societal level, for example films or TV news programmes, or talking to the families of veterans. I acknowledge that there are other sources that could have been sampled that would have produced different results. However, the data source that I have chosen to select in this research is newspaper articles.

Whilst it cannot be argued that newspaper articles straightforwardly represent people’s perceptions of a topic, it seems likely that at least they influence the discourses around a topic that exist in society. Most people have some access to news reporting, whether in print form or via other media. Whilst only a minority of people will have had any experience of trauma within a conflict situation, it is likely that most people will have been exposed in some way to media discussions of the topic, and may or may not have formed their own opinions as influenced by them.

In the light of this, I would argue that the discourses that are deployed within a newspaper articles influence the ways in which people in society construct trauma.
Therefore, in Foucauldian Discourse Analysis terms, it would follow that these constructions both make possible and deny certain ways of being that become understood within society as being reality, thus potentially serving to mask power relationships. For example, it could be argued that men's magazines construct 'being a man' in particular ways, which constrain the experience of being a man in contemporary culture. Also, given the imminent withdrawal of UK troops from Afghanistan, and recent ongoing unrest in the Middle East, representations of veterans' issues are likely to be high profile in news reporting. Therefore, a fuller analysis of the research question requires a consideration of the cultural discourses within which individual discourses are situated.

I am not claiming that the focus group and newspaper data are comparable in any way, and indeed, discourse analysis does not seek to make comparisons (Parker, 1992). Rather, I am using an analysis of newspaper articles as a way in which to contextualise the research question, and provide a cultural counterpoint to the constructions of trauma being deployed in the focus groups. It is hoped that combining both these data sources will lead to a more meaningful analysis that embraces the Foucauldian spirit.

Media studies methodology sometimes advocates a discourse analytic approach. One of the key functions of a news text is to represent other entities, whether that be people, events or institutions (Fairclough, 2003). If a news text represents these things in an article, they can be framed in a particular way to privilege certain views. Consequently, it is important to consider the context of how and where the article was produced and the political leaning of the newspaper; a consideration of what is beyond the immediate text. Although this makes it difficult to examine the difference
between rhetorical device and 'reality', what can be done is an exploration of how discourse influences the claiming of certain positions within a publication. This is useful to consider alongside the focus group data for the reasons mentioned earlier. I also acknowledge that the newspapers, which were selected according to which had the highest circulation figures, may represent a narrow example of British news reporting, for example they are skewed in favour of right-wing leaning publications. Despite this, the decision was taken to use them as they offered the widest coverage of news reading people in the UK, due to having the highest circulation figures.

Sampling strategy

Newspapers were selected by looking at circulation figures for the UK, and from the most widely circulated, a broadsheet, middle range and tabloid paper were chosen. This was the Telegraph, the Mail and the Sun. Examples of articles selected can be seen in Appendix 3.

A purposive sampling strategy was used in order to explore the newspaper data sources, which were accessed via a news database (Nexis). I looked for examples where constructions that emerged in the focus groups were evident also in the newspaper sample. Examples of where constructions were contradictory to this were also collected and explored. An example an analysed article can be found in Appendix 2.

The newspaper database Nexis (http://www.nexis.co.uk/) was used to search newspaper articles in each of the three publications. The search terms 'UK military' plus each of 'mental health,' 'trauma,' and 'PTSD' were used from the year 2000 to
the present. A total of 62 articles was returned. The search terms used were: UK military plus ‘mental health,’ (23 returns), plus ‘trauma,’ (19 returns) and plus ‘PTSD’ (20 returns). After excluding articles which were duplicated, this generated a list of 57 articles, 19 from The Telegraph, 23 from The Mail and 15 from The Sun. From these, a purposive sample was selected. I looked for examples where constructions that emerged in the focus groups were evident also in the newspaper sample. Examples of where constructions were contradictory to this were also collected and explored. Discourse Analysis was then carried out on these articles in accordance with Willig’s (2003) six stage methodology.

**Ethical Approval**
The focus groups for this project were conducted by a previous trainee clinical psychologist. She submitted her project to the Faculty of Arts and Human Sciences Ethics Committee at the University of Surrey on the 15th July 2010 and was granted a favourable opinion on the 29th July 2010 (Appendix 4). In order for me to use the data, participants were contacted to seek their consent for the data to be used by subsequent trainee clinical psychologists at Surrey University (which was granted) and guidance was sought about whether further ethical approval was needed. It was agreed that as long as no participants raised objections, that the data could be used by me and that no further ethical approval was needed. Obviously no ethical approval was required for the analysis of documents already in the public domain.
I have followed here the 6 stages as outlined by Carla Willig (Willig, 2008) However, these stages are not necessarily discrete, but often merge into each other, and obviously require extensive close readings of all the collected material. The stages are:

1 – Discursive Constructions

2 – Discourse

3 – Action Orientation

4 – Positionings

5 – Practice

6 – Subjectivity

See Appendix 5 for a fuller description of these stages.
**Analysis**

Although I was looking in the data for examples of constructions of trauma, it became clear that although participants were not necessarily talking about PTSD itself, they *were* talking about psychological distress related to combat, and contextualising it within constructions of what it means to be in the army or maleness for example. A criticism of this study could be, how can it be known that veterans in the focus groups and journalists in the articles are talking about the same thing, and that the thing is trauma? The answer is, it can’t; but what is known is that people are talking about distress which they relate to working in a combat zone. I am using the construct of PTSD as an anchor point by which to explore how trauma is constructed because this is largely used within the military and clinical context. I do not imply that the focus group participants are talking about PTSD. However, ‘distress that people experience which they relate to working in a combat zone’ being something of an unwieldy phrase, I have chosen to refer to this concept in all its different constructions as ‘trauma’. I hope this allows me to avoid the endless caveats that would be required in trying to pin down a concept that I argue is socially constructed and mediated by culture.

*Constructions in the focus groups*

As mentioned earlier, the six-stage approach to analysis was used (Willig, 2008). The sections below represent the different constructions of trauma (or being in the army, or maleness) found in the data. The focus group data is tackled first, followed by the newspaper sample. Following this there is a synthesis of the two analyses.
Extracts to illustrate particular constructions have been taken from transcripts of the focus groups or article text. I acknowledge that other extracts could have been selected, and that my selection is part of the constructed nature of this research. For reasons of economy of space, I have sometimes omitted certain parts of an extract, which is demonstrated by the use of ‘....’ I have also specified if the extract is from an officer or non-officer group, or what newspaper the extract is taken from. Examples of the text can be found in appendices 1 and 2.

The constructions from the focus groups presented are: Training suppresses trauma, constructions of masculinity and the army, constructions of a soldier’s identity and constructions of trauma from the present looking back. In the newspaper sample, the constructions identified are: Training minimises trauma, being part of the group is more important than acknowledging trauma, trauma as problems adjusting to civilian life, trauma as a wound and constructions of the trauma industry. A synthesis of the two data sources can be found after this.

**Training suppresses trauma**

Participants talk about military training as a way of making trauma less likely to be a problem. Trauma is constructed as rare; training allows soldiers’ feelings to be suppressed, has a protective function and minimises the likelihood of developing trauma.

The extract below shows a construction where military training teaches soldiers to suppress feelings that may be related to trauma. This was part of a conversation about not wanting to talk about ‘it’ [trauma].

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...you have to have that impenetrable armour around you...And on the whole I think people just brought the shutters down when they went on tours, you have to compartmentalise your family, just get on with the job and do it. When you come back there is another job to be done so you just get on with that one. And the whole training is just suppressing all of it. The reality of training nowadays, which is so much better than it was twenty years ago, I think all of the wounds are much more realistic the effects of IED (improvised explosive device) are much more realistic than the way we used to train it teaches people not to be affected by the immediacy of the incident to suppress the rogue feelings and get on with the job and carry on with the mission ad hoc.' (officer)

This constructs ‘not thinking about trauma’ within the context of a successful outcome of military training. It also constructs a reality where training allows a soldier to get on with his job, whether that is combat or other duties. It functions as legitimising not thinking about trauma, as this ensures psychological survival.

The extract above also presents training as allowing soldiers to suppress their feelings. The use of ‘rogue’ in relation to feelings presents them as something out of place. This functions as constructing feelings as undesirable and unhelpful, legitimising their suppression through training. This creates a potential subject position where you can only function well if you have, in accordance with your training, not allowed yourself to be affected by feelings and instead ‘get on with the job.’ This makes any other position impossible; anyone not able to get on with the job would not be successful in the role of soldier, perpetuating the norm that
suppressing feelings is the sanctioned solution and essential for both psychological and career survival.

**Constructions of masculinity and the army: ‘maleness intensified’**
Constructions of trauma in the focus groups are embedded within other constructions, for example masculinity and what it means to be in the army. Constructions of masculinity in the army mediate the availability and nature of trauma-related discourse. The construction explored below is primarily concerned with how the men in the army are constructed as being ‘extreme’ versions of maleness, which is both a requirement of maintaining a successful identity as well as affecting the availability of discourses with which to talk about emotional distress. In response to a question from the researcher about what soldiers should do if they experienced psychological distress, and a general discussion about there being people soldiers could talk to about this more nowadays, one non-officer commented:

> It’s a male thing anyway isn’t it, and the Army is like maleness you know intensified isn’t it? That’s what I think. Men are less likely to go and talk to people anyway, and the army just makes that even, you know that much more difficult I suppose.’ (non-officer)

In this extract, the army is constructed as a form of ‘extreme maleness’ associated with ‘not talking,’ thus making a legitimate identity which includes seeking help for (and thus acknowledging) trauma untenable. This position means the status quo prevents people legitimising an identity which includes talking to outsiders about distress. In the extract, this construction is presented as fact and therefore an
extension of something typically true of all men. This makes it seem obvious and accepted; men don’t talk, army men are ‘extreme’ versions of men, therefore it follows that they certainly won’t talk. This extract also presents a construction where maleness is equated with not talking about feelings, which influences the subject positions available for soldiers to construct a subjective identity as they manage multiple identities in their stake in the focus groups. The categories of ‘maleness’ and of belonging to the army are also presented as static, the function of which is that it makes it difficult to challenge either.

In both focus groups, soldiers are constructed as being ‘too tough’ to be affected by trauma. For example, in the male officer focus group, there is a construction where an experience would have to be extraordinary in order to traumatisise a soldier.

Most soldiers do not get past basic training unless they are fairly robust nowadays ....the majority of soldiers are quite tough animals and it takes something special in 99 out of a hundred cases to bring on this post traumatic stress thing.. The vast majority of them may be affected as well would be for short periods after but that they can recover quite quickly.’ (officer)

There is a contradiction here in that on the one hand, trauma is constructed as a common experience and on the other, as something which would not occur a great deal. These two ideas appear incompatible but are presented as straightforward. If soldiers are ‘robust’ and it takes ‘something special’ to cause trauma, then within this discourse, a soldier who did experience trauma could not be robust. The extract also constructs a reality where any negative effects could be easily got over by a tough soldier. This functions as minimising the impact of trauma as well as legitimising the
‘tough’ aspect of what it means to be a soldier as in itself helping prevent such problems.

This extract also demonstrates the use of extrematisation. Trauma is constructed as something both extraordinary and statistically infrequent; it is something exceptional and not part of normal combat experience. This might make it less available as a discourse for soldiers to use. It also constructs the experience of trauma as being on a continuum; someone could suffer a bit but then be alright again, but serious long term cases are rarer.

**Constructions of a soldier’s identity: ‘you make sure you’re in the squad’**

Discourses available for constructing trauma are embedded within constructions of a soldier’s identity. The extract below constructs a homogenised picture of what it means to be a soldier, where standing out in any way (for example by suffering from trauma) would have negative consequences.

‘I think if there’s a weak member of the troop they would undoubtedly be discriminated against, intimidated to bring them back in line with everybody else... You wouldn’t bring up that you had a weakness because you wouldn’t want anyone to know you had a weakness. ‘you make sure you’re in the squad, you’re in the bulk of it, you don’t want to be right out the front...but you don’t want to be left behind either, there’s a sort of safety in being in the bulk.’ (non-officer)

This positions the ‘bringing into line’ as the overall function of the intimidation. This idea of being removed if you are different is presented as being true if you are too strong as well:
‘We used to have super-fit blokes in the commando brigade, super fit, and they didn’t fit the bill...they used to say this to make me laugh ‘What are you going to do when you get there by yourself then? Even super fit blokes ideally can be a weakness you know.’ (non-officer)

This constructs the idea that there is a template for soldiers, and that deviating from this in any direction is not tolerable. The function of this is that it legitimises restorative actions if anyone should deviate from the norm. Internal regulation in the system means it is the soldiers themselves that are doing the eliminating and ensuring that any deviation is hidden, as the consequences of being atypical would be undesirable and thus something to be avoided. The only ‘safe’ position to inhabit is presented as being within the cohesion of the unit, being the same as everyone else, which inevitably impacts the availability of an identity which includes experiencing trauma.

Constructions of trauma from the present looking back
The officer focus group discuss how history has given trauma various different names, which functions as allowing certain types of traumatic experiences to be legitimised over others.

...going from your grandfather’s day.. actually the trauma bit was called cowardice and people were, of course, shot for it. And we caught families trying to actually recover the family honour. All the way through social change to now we actually have PTSD in all its guises and so you have got to work out whether it is a social trend or whether we have become less able to put up with the nasty side...In 1916 there were 32 second lieutenants in the black watch , I suppose, slaughtered, and you thought ‘hang on for every one
of those there were probably 150 toms taken out and just the sheer scale of what they had to go through makes most of what we do pale into insignificance...life was a hell of a lot tougher for almost everybody...we are much softer on ourselves than probably people were...I believe they were in a way, mentally tougher.... I would go back to my serving day when we saw PTSD as a holiday thinking that’s brilliant.’

This extract compares ‘realities’ of the two world wars and conflicts today. Constructing people as just ‘harder’ in the past reinforces the discourse where experiencing trauma in the army today is indicative of weakness. By raising the historical view of equating trauma with cowardice, this image is strengthened and maintained, closing down the possibility of someone experiencing trauma today if they haven’t had comparable experiences. This doubly devalues trauma in the contemporary army; not only is it potentially a sign of weakness in itself, it is also compared unfavourably with what soldiers in ‘proper’ wars had to go through.

The extract above also illustrates the way in which PTSD is being presented as a construct. Presenting it as a ‘social trend’ rather than a personal reality serves to further devalue it as a legitimate experience, as it presents a version of trauma as being culturally constructed rather than something ‘real,’ for an individual, which could serve to minimise experiences of distress.

**Repertoires in the Newspaper Sample**

As with the focus groups, the newspaper sample was analysed according to the six stage method (Willig, 2008).
Training minimises trauma: ‘war is a stressful business’

As with the focus groups, the newspaper sample also demonstrates a construction of military training as minimising the likelihood of a soldier suffering from trauma.

This idea that being a soldier can simultaneously expose someone to traumatic situations (i.e. war) whilst also protecting them from PTSD (due to their training) seems contradictory. However, the extract below, from a newspaper article in the Daily Telegraph, constructs these two ideas as not mutually exclusive. It focuses on examining neuroscientific research into PTSD in the military. Already, the constructions within this article are located within a scientific discourse where ‘facts’ about PTSD are ‘discovered,’ and doctors’ and professors’ opinions are used to legitimise these facts as if they are part of an objective reality. That this discourse exists in a journalistic context could also influence wider perceptions about the ‘science’ behind our understandings of trauma and PTSD.

‘But Professor Wessely has found that the very thing that exposes soldiers to PTSD might also help them deal with it: their job. According to his research at King’s, group cohesion and firm leadership are critical in reducing the impact of psychological distress.

“You have to remember we are talking about professional soldiers who have been highly trained,” he says. “Their training is designed to harden them against the unpleasant nature of war. The military is actually very effective at reducing the risk of PTSD with their training, their professionalism, esprit de corps and morale. War is a stressful business and this all prepares soldiers for that”.'
This extract constructs trauma as something less likely to occur due to the comprehensive nature of military training; in this example the army as an employer is constructed as a body that protects soldiers from trauma. This position is given gravity by being ‘backed up’ by research. By constructing cohesion and firm leadership as ‘critical in reducing the impact of psychological distress’ this closes down the possibility of challenging the legitimacy of this approach, as the alternative would result in failing to reduce psychological distress, a clearly undesirable thing. That training can protect soldiers from trauma is presented as an objective reality, masking any possible power dimension that could be reproducing the culture that makes it impossible to seek help if suffering from distress.

Claiming that the training soldiers receive can ‘harden’ them against the ‘unpleasant nature of war’ removes the possibility of someone who has been ‘successfully trained’ as someone who is able to acknowledge being affected by trauma. The extract claims that training reduces the risk of PTSD with its ‘professionalism, esprit de corps and morale,’ making such an approach appear desirable and positive. This constructs training and a lack of trauma as linked, which also functions as suggesting that if a person was acknowledged to be suffering from trauma then their professionalism might be questioned, rendering it an undesirable subject position.

The extract below (from the same article) also presents existing structures within the army as making individuals well able to cope with any distress.

Although psychological damage is as much part of war as physical damage, he [Prof Wessley] believes British troops are well prepared to
cope with the stress of conflict. "I don't think they are more psychologically stressed from seeing terrible things than doctors or nurses."

The risks of post-traumatic stress disorder are far higher if Servicemen and women do not trust their equipment, are younger, come from lower socio-economic backgrounds and have past trauma.

But a key factor appears to be the level of support from their peers and friends.

(The Daily Telegraph, Wednesday 12th March, 2003)

This extract positions military PTSD alongside the 'psychological stress' experienced by doctors and nurses. It also constructs trauma as related to something else entirely, such as having past trauma or coming from lower socio-economic backgrounds. This functions as providing a greater sense of control and predictability, as it raises the possibility that it might be possible to identify individuals at greatest risk. This functions as minimising the idea of there being anything unique about military trauma, removing the possibility of investigation into how the army training and support systems could facilitate acknowledgement of distress and access to help. This construction locates trauma within the individual rather being due to conflict experiences. This may serve to reinforce existing power dynamics where soldiers suffering from mental distress are not able to acknowledge trauma whilst serving as it might be related to something 'weak' about them. This also functions as minimising organisational responsibility.
**Being part of the group is more important than acknowledging trauma**

The newspaper sample contains constructions of the importance of being part of a cohesive group to the identity of a successful soldier, and how this prevents acknowledgement of suffering from trauma. This suggests such a construction may be part of a cultural repertoire that soldiers both draw on and contribute to, maintained in wider society by a contemporary endorsement of this view. The extract below, from the Sun, details the experiences of Bob, a former SAS soldier who has experienced trauma. This extract also resonates with the construction of masculinity discussed earlier.

Bob, from Hereford, said: "The more macho the unit is, the worse the problem is.

The regiment is special, yes, but its members are still only human. It's often very easy to forget that."

Bob joined the SAS in 1994 from the Royal Engineers and was posted to B Squadron's Mountain Troop. His problems started after stressful secret work in Bosnia and Northern Ireland.

They began with flashbacks and went on to road rage and a failed marriage. Bob said: "I'd pull people out of cars for little reason and I'd even have a go in Tesco."

But he kept his problems a secret. He added: "There is pressure on you not to admit to anything because you fear you'll lose the trust of your mates."
The worst fear everyone in the SAS has is that they'd get binned from the unit if they said something - and they probably would."

(The Sun 25th August, 2009).

This extract demonstrates a construction where a soldier cannot claim trauma as an experience while serving in the army (particularly the SAS) if he wishes to also maintain an identity as a successful soldier. Bob's construction of his experiences functions as demonstrating how little power soldiers like him have to acknowledge trauma and maintain the respect of their friends. This is situated within a heroic narrative; the unit is tough, the work is extreme and there is little support for distress, but Bob (and his colleagues) manage to survive despite this. This allows Bob to manage his stake successfully, but as it is part of a newspaper article, also allows the journalist to portray Bob's experiences as an example of what is typically true, perhaps to elicit a response in the reader to support the writer's (and perhaps the newspaper's) political position.

By highlighting the fear of being 'binned' from the SAS for acknowledging trauma, the article also places the responsibility for this inability to admit distress beyond the speaker. This functions as constructing a reality where all the power is held within the army as an employer. This institution occupies a position of both endorsing a self-regulating system that means that distress is not acknowledged, where a macho culture is perpetuated and is perhaps even necessary for people to do their jobs effectively, and also where if people do not fit in and admit they have a problem, then they would be rejected from this structure. Bob (and the article's writer) presents a static system that does not allow any deviation and makes challenging the
status quo difficult, which perhaps fits with the article writer's possible discursive aims in critiquing such a system.

**Constructions of trauma as problems adjusting back to civilian life: ‘People were just getting on with their lives’**

The articles in the newspaper sample construct stories where trauma only becomes part of identifiable experience once a soldier has left the army and is returning to civilian life. It is constructed as a problem in making this transition.

This extract is taken from an article in which a Falklands veteran tells his story. In it, he constructs his understanding of how trauma affected him in terms of the problems he had when he returned home. He says that on returning from the Falklands:

‘I was in a mess... not physically, but the experience had deeply affected me in ways I didn’t understand. It was great to be home in one piece and among my loved ones, but I was struck by how normal everything looked. People were just getting on with their lives. They had no idea what we had seen and been through....The war and my part in it became like a dirty secret for me. But deep down I felt a mixture of guilt and anger. Why had my mates had to die? Depressed and introspective, like hundreds of other veterans, I started drinking heavily and getting into fights. I went on some epic binges and brawls.

(Daily Mail, 5th March 2012)
This shows a construction of trauma as the experience of being unable to fit back into civilian life which then leads to behaviours such as drinking and fighting. It is also an example of self-inoculation on the part of the speaker; he legitimises his behaviour (drinking and brawling) by aligning it with 'normal' behaviour amongst veterans, behaviour which is constructed as understandable in the light of the strong emotions evoked by extreme adversity and the death of friends. This is located within a context of feeling isolated; 'normal' people were 'just getting on with their lives' and thus are constructed as very different from the type of person represented by the speaker.

Constructing trauma in this way potentially serves several functions. Firstly, it locates trauma within the social world. Its effects are seen in a veteran’s experiences on re-entry to civilian life, which others cannot understand. In the example above, describing problems with alcohol or violence are juxtaposed with the adversity the person has experienced, and this means they can be legitimised as an understandable response. The result is that responsibility for the behaviour described, even if it is a reaction to traumatic events, is placed within the wider social world. This construction also closes down the possibility of understanding trauma as something located within individual vulnerability factors. If trauma is something located in the social world, then this has implications for where the responsibility for its management should lie.

*Trauma as a wound*

There is a repertoire in the newspaper sample where trauma is constructed as being a wound, and situated alongside a discourse of physical injury.
Across the articles selected, phrases such as ‘invisible wounds’ and ‘hidden scars’ are used. However, there are some contrary discourses which construct trauma in terms of the visibility (and seriousness?) of physical injury, and which thus deserves equal levels of care and compensation. These constructions locate trauma within a medical discourse, where it can be given a definable cause, clear symptomatology, and treatment. The function of this is that it raises the status of trauma as a condition, allowing its treatment to be evaluated on the same terms as provision for physical injuries. A further function is that it highlights the gap between how one group are treated in comparison with another; juxtaposing the two provokes questions about why there is a disparity in treatment.

The extract below is part of The Sun’s ‘campaign to help traumatised squaddies.’ Here, mental health problems are constructed as being equal to physical injuries in terms of both being taken seriously, and in individuals’ rights to access treatment.

The Sun today issues an immediate call to arms over the mental health ticking timebomb affecting our battle-scarred troops.

New MoD figures show that 3,970 personnel were diagnosed with a mental disorder in the year to September 2010.

Today we demand:

An assurance that all servicemen and women returning from Afghanistan can have an automatic appointment with an INDEPENDENT psychiatrist.
That compensation payments for those left unable to work through mental health issues - such as severe post-traumatic stress disorder - are in line with those for physical injuries.

Here, we talk to one soldier who has returned from war with mental scars even worse than the terrible physical injuries he suffered.... Barely 18 months ago was the corporal blown up TWICE in six weeks in Afghanistan.... He medically "died" on the operating table, his spine shattered, his spleen destroyed and his brain haemorrhaging.

But yesterday Cpl Lock told how his injuries were "child's play" compared with his long battle to get help for severe posttraumatic stress disorder (PTSD) brought on by the horrors of war.

(The Sun, Tuesday 25th January, 2011)

This extract presents a construction of reality where soldiers suffering from trauma are in need of help but not getting it. The Sun 'demands' equal compensation as those with physical injuries, which functions as highlighting the disparity between treatment for physical and mental injuries, as well as pushing the needs of trauma sufferers higher up the political and economic agenda. The article extrematises this particular soldier's experiences of war by cataloguing the various terrible experiences he had, culminating in one where he 'medically died'. The function of this is forcing the reader to question how such suffering can go unaddressed, and highlighting this within a highly emotive discourse of almost superhuman suffering and struggle serves to challenge the current provision of care received by veterans.
Another article says:

Writing for the Daily Telegraph, Mr Cameron says people must recognise that mental battle scars could be as serious as physical injuries.

He says: "Very few servicemen and women with mental health problems go looking for treatment.

They don't want to make a fuss, and so suffer in silence rather than seek help. This requires us to be more proactive, reaching out to them.

We need a national change in attitude towards mental health and combat stress - recognising that the mental scars can be every bit as damaging as the physical ones."

(The Daily Telegraph, Friday 11th March, 2011)

Here, trauma is constructed using the discourse of physical injury and is placed within a medical model where 'mental battle scars could be as serious as physical injuries'. The Prime Minister acknowledges that veterans do not often seek help, but attributes this to their not wanting to 'make a fuss'. This simultaneously maintains their positive identities whilst equating 'asking for help' with 'making a fuss', consequently making it appear undesirable. This construction also locates the source of trauma as well as the capacity to ask for help within the individual, and does not acknowledge any organisational or institutional factors that could be influential beyond a more non-specific notion of a 'national change in attitude'.
Constructions of ‘the trauma industry’

Some articles in the newspaper sample construct trauma as part of an ‘industry’ which functions as constructing a hierarchy of what constitutes ‘proper’ trauma. The idea of only some kinds of trauma being legitimised is set within the context of comparing civilian and military cases. The following extract is from an article that highlights how veterans are not receiving appropriate care for PTSD, but places this within the context of a growing ‘trauma industry’ in which people are able to claim trauma as an experience in order to get compensation for their suffering.

This extract from the Telegraph constructs civilian trauma as worth less than military trauma.

One such victim who featured in the programme was a nurse who was in a taxi that was hit from behind. She suffered bruising and was diagnosed with PTSD, and later with a psychological condition that causes pain and disability but with no obvious physical cause. Yes, I felt sympathy for her - until she was asked: "What do you say to people who say you were only in a minor traffic accident... you haven't been bombed in Baghdad?" She replied: "That was my war. That felt like my war, that day."

Her "war" was very different to that experienced by Andrew Watson [veteran whose story was told earlier in the article] - as was the help and support available to her.

(The Daily Telegraph, Wednesday July 29th, 2009)
This extract demonstrates a construction and critique of PTSD as a fluid concept that can cover both being in a car accident as well as being ‘bombed in Baghdad.’ This is located within a wider discourse of a ‘compensation culture.’ Juxtaposing the two potential ‘causes’ of PTSD functions both as presenting one as more deserving than the other, as well as allowing a critique of PTSD as a potential ‘catch all’ diagnosis. The function of this is that it raises questions about how people with very diverse experiences can claim trauma if their symptoms fit the criteria for PTSD. The writer positions himself as critical of this by comparing opposite ends of the drama spectrum with the civilian’s description of her experience as ‘my war’ and the example of being bombed in Iraq. This extrematisation functions as strengthening the critique.

Further constructions of a trauma ‘industry’ in the newspaper sample function as questioning what is a legitimate traumatic experience. The extract below demonstrates a construction of PTSD as something which allows undeserving people to acquire compensation.

As a nation, we have never been safer, richer, and healthier -- for one thing, the Luftwaffe is no longer overhead -- so where has all this ‘trauma’ come from? There’s doubt that some of it is genuine. Soldiers and civilians do experience terrible events -- and are left emotionally scarred by them. These victims deserve proper, dignified care.

But many experts argue that a whole industry has grown up around PTSD -- and it is not just about making damaged people better.
It's a money spinner. Let's be blunt about it. If you've got the prospect of £100,000 by continuing to have headaches, flashbacks, insomnia -- you can see why people may not find it easy to relinquish those symptoms....

These symptoms are not exclusive to PTSD, but the thing that did make PTSD novel was that your trauma could be linked to a specific 'index event' -- an ambush in Vietnam, an explosion or a helicopter crash. And because something or somebody caused your mental illness, you could sue them for it.

(Daily Mail, Monday July 27, 2009)

This extract clearly constructs two 'versions' of trauma; one that is 'genuine and legitimate,' (and not exclusively experienced by soldiers, although they are a defined group within the discourse) and who deserve care, and others who are part of a trauma compensation culture. Setting this within a construction of contemporary life which is constructed as the pinnacle of being safe, rich and healthy also functions as constructing trauma within the 'non-deserving' groups as something that both should not happen and is not as important. This positions those who claim trauma as an experience (but who are not soldiers or civilians who have experienced 'terrible events) as weak or fraudulent.

Constructing legitimate and illegitimate versions of trauma functions as allowing the writer to focus criticism on the way the PTSD and compensation industry is set up, rather than on individuals who may or may not be experiencing symptoms. Despite having earlier acknowledged that there are 'genuine' cases, the construction of an 'illegitimate' version of trauma makes it difficult to further explore how these two
versions of trauma might be differentiated, and what criteria might be used for this. This further destabilises the possibility of achieving any clear understanding of what trauma is; there are some ‘genuine’ cases but even though both ‘types’ might meet the criteria for PTSD, it is not known how the two types can be defined.

Synthesis between the focus group and newspaper repertoires
The analysis of the two data sources has shown that there are some constructions of trauma evident in both, and others which only exist in one or the other. Before going on to explore this further, it seems important to again acknowledge at this stage the influence of me as a researcher in the construction of this particular story around trauma. Whilst conducting the analysis, it was clear that the limits on the scope of this study meant that certain discourses could not be included and much rich and significant detail was necessarily omitted from the finished analysis. This is an example of the constructed and constructive nature of research. Why did I elect to include some repertoires but not others? The answer to this is that I selected material where there were several instances of a particular construction rather than when there were only one or two. When analysing the newspaper sources, I took a similar approach, and chose to present constructions that were both more commonly found across the sample, as well as which had some resonance with what I found in the focus groups, in order to give the analysis overall coherence. However, there were many other examples that could have been used, and further work could focus on this.
Similarities between the data

There are points of similarity and difference between constructions found in the focus groups and those found in the newspaper sample. Even where there are areas of convergence between repertoires it appears that their function can sometimes be different.

The focus groups largely present exposure to traumatic events as ‘just part of the job’ and construct military training as something which prevents soldiers suffering with trauma by suppressing feelings; the ‘just get on with it’ attitude is both inevitable and the best way to ensure psychological survival. In one of the newspaper extracts outlined above, a scientific discourse is employed to construct the function of training in minimising PTSD. Although related, these two repertoires appear to function differently. The focus groups construct training as a way of suppressing feelings whereas the article constructs it as something that means a soldier will not be seriously affected in the first place; it would not be necessary to suppress feelings because the likelihood is they just would not be there. The functions of these constructions also suggest something about the power dimensions of what is legitimised as experience. Findings underpinned by ‘science’ are presented as fact, so that if someone experiences trauma after having been through training, this can be attributed to their own personal weakness rather than inviting questions about how best to manage those psychologically damaged by war. It is also noticeable that the way the officer focus group construct trauma as something quite extraordinary seems more functionally aligned with the constructions in the article. It could be argued that this alignment reproduces the power structures inherent in a war fighting situation, where non-officers are more likely to be in front line roles (and needing to suppress
their feelings), whereas ideas about trauma are instead studied, talked about and owned by those from the scientific or officer community. It might be that this reflects a wider political purpose on the part of the newspaper articles which seek to challenge the policies of the government or demonstrate their own caring credentials. Soldiers however, may instead have the purpose of understanding their own experiences or maintaining positive identities of themselves.

In the focus groups there are constructions of soldiers' experiences where any emotional distress must be hidden in order for a successful identity to be maintained. This contributes to a discourse of invisibility around trauma. The idea of losing the trust of friends if you experience trauma is found in both samples too; being part of the team is constructed as a desirable position, which means that doing anything to risk this (such as admitting you have a problem) would be neither desirable nor likely.

This discourse of trauma being hidden is found in the newspaper sample, but it is juxtaposed with a discourse of physical injury, with phrases such as 'invisible wounds' and 'hidden scars' frequently used. In some articles, this functions as mobilising the comparison as a way to highlight disparities in how those suffering from physical and mental distress are understood and cared for. In the focus groups, constructing trauma as hidden and invisible prevents the availability of a discourse where someone could successfully situate themselves outside of the homogenous 'successful soldier' group; trauma is hidden because if it were visible this would involve standing out, potentially a more threatening situation that suffering trauma in silence. The discourse of physical injury deployed in the newspaper articles however functions as both dramatising and exposing the effects of trauma, perhaps
functioning as giving a voice to a group who are unable to claim the experience themselves.

**Differences between the data: discourses of masculinity**

Some repertoires were evident in the focus groups but were not found in the newspaper sample. An example of this is the discourse around masculinity. In the focus groups, this functioned as a key aspect of how soldiers constructed their identities and mediated their ability to admit experiencing emotional distress. That this was not found within the newspaper sample suggests that there may be something about the construction of this identity key to being part of the army community. In the newspaper sample, there almost seems to be a contrary discourse, where soldiers are constructed as in need of and deserving help and support; while there is a discourse of heroism evident, the version of self-sufficient masculinity is not part of this. This perhaps indicates a disparity between perceptions of military identity from within and outside the army. It may also be related to the different functions served by the soldiers and newspaper articles in presenting trauma in this way; soldiers are able to preserve a culturally endorsed successful identity, whilst the newspaper articles can align their publication with a caring and socially responsible discourse which may increase loyalty amongst their key readership.

It could be argued that for the focus groups, it was more necessary for the participants to successfully manage their masculine identities than is the case in a newspaper article. This could explain why there is no discourse of masculinity to be found in the article sample at all; it is simply not necessary. In the focus groups however it functions as a marker of what is required to be a successful soldier. It can
also serve a protective function in that it helps facilitate unit cohesion which is itself constructed as being key to managing difficult feelings. However, in the newspaper articles, the veterans are constructed as deserving of help but not asking for it; it is perhaps more acceptable to consider the need to ask for help in a wider cultural context than it is in the specific context of serving in the military.

**Discussion**

**Summary of Discussion**

The analysis of both the focus groups and the newspaper sample show that trauma is constructed in different ways and that these constructions serve particular functions for the speaker or writer. For the focus group participants, constructions of trauma are also bound up with constructions of what it means to be a soldier, and what is required to maintain a successful identity as a soldier functions as constraining which experiences of distress can be legitimised. For example, one construction is that to be successful in the army, a soldier must not stand out from the crowd; to admit trauma would be to do just this which could jeopardise group membership. The system self-regulates as the soldiers themselves construct a version of their unit where difference is highlighted, identified and then removed, which makes it difficult to challenge as soldiers are both the victims and the creators of such a system.

Unlike the focus group participants, the newspaper articles are not constrained by the necessity to maintain a successful identity as a soldier. As a result they function differently, positioning constructions of trauma within a scientific and medical context and foregrounding the superhuman suffering of the veterans they have selected to interview. In this context, an identity aligned with trauma is not
associated with weakness; it is located within a war hero discourse. This functions as elevating the status of individuals who manage to survive despite having had horrific experiences and not receiving sufficient help in the UK. This allows the article writers to present a critique of the current organisation of services and indirectly, the government. For a newspaper, constructing experiences of trauma in this way also allows an editorial position of being on the 'side' of a suffering war hero, thus improving its caring credentials amongst its readership.

Across the data sample, soldiers’ experiences of distress are also not aligned with the PTSD category. As a result of the potential gap between the PTSD profile and the culturally-mediated experiences of distress described by veterans, it seems likely that some veterans’ personal narratives do not necessarily fit a clinical profile, which although heavily criticised is still widely used. This, combined with difficulties in help seeking in this group, may mean that distress that could be treated remains unaddressed. It also raises issues about the usefulness of applying static mental health labels to those experiencing distress.

**This study in relation to other research**

It is interesting to note how there has been a great deal more research into military trauma in the last ten years. It might be that trauma is more culturally available as a topic, or that, considering the wide public unpopularity of the UK’s involvement in 21st century conflicts so far, research which appears to show minimal ill effects on soldiers’ mental health (e.g. Fear et al, 2010) might be mobilised politically as evidence that the ‘true’ effect of conflict is not as bad as people might imagine.
Although research has found that there has been no increase in reported mental health problems amongst troops (Fear et al, 2010), this may just mean that soldiers are not reporting problems rather than they do not exist. The focus groups and newspaper sample showed examples of people reporting distress but not calling it by a mental health ‘label.’ This suggests there is a gap between how some mental health professionals and diagnostic systems may define a mental health problem, and the linguistic resources soldiers have to describe their experiences of distress.

In this way, change at an attitudinal level might be necessary before soldiers can claim trauma and maintain a successful military identity. This demonstrates how a discourse analysis perspective on these issues can further the understanding provided by other research. Although superficially it might appear that the soldiers in the focus groups do not claim trauma as part of their identity, exploring the function of this, (maintaining cohesion and not wanting to stand out from the crowd, itself endorsed at an organisational level) goes some way to uncover the social forces that might create or constrain the ways in which individuals understand their experiences.

It has been argued that the focus on PTSD may obscure areas of other mental health need amongst veterans such as anxiety, depression, adjustment disorders and alcohol misuse (Miller and Rasmussen 2010; Sammons and Batten, 2008). This idea is echoed by Maguen et al (2010), who assert that alcoholism is itself used as a mechanism to cope with the distressing events witnessed or experienced during deployment. This suggests that a holistic assessment of distress related to war is vital in understanding how best to help those affected.
**Why might trauma sometimes 'look like' something else?**

Participants in the focus groups did not necessarily connect the term ‘trauma’ to their own experience, or used other terms instead. This raises questions concerning how we know we are talking about trauma in the first place. The discourses identified in this study are organised around the central idea of trauma, but veterans often talked about it in a more general sense of ‘difficulties.’

This is also important when considered in the light of what is required for a diagnosis for PTSD. The symptom profile for this is very clear, but does not take into account all of the context of what is actually reported by soldiers when asked about trauma (in these focus groups at least). This raises questions about whether it is possible or desirable to pre-define what someone has to experience in order to be suffering from trauma in a diagnostic sense. This is important because access to services and treatment are dependent on people being classified in this way. It has been argued that soldiers might lack a language with which to express distress (Green et al 2010), and therefore, leaving aside the problems of their seeking help in the first place, not everyone suffering from distress as a result of their military experiences might recognise the PTSD specific symptoms; a static concept of trauma cannot accommodate all the variations of distress possible within a group that rejects the identity of trauma. This questions how useful the concept is in this population as a measurement of distress. This is particularly important given that the recorded prevalence rate for PTSD in UK veterans is 3-6% (Richardson et al, 2010) but that there seems to be large amounts of distress in veterans outside this. As mentioned earlier, there are much higher rates of military-related PTSD in the US compared with the UK, which may reflect differences in how veterans report mental distress.
This again supports the cultural specificity of the PTSD construct and the argument that distress in cultural groups may be conceptualised differently (Summerfield, 1995, 2001). These difficulties also support the critiques of PTSD discussed in the introduction section, particularly in relation to the importance of how an individual cognitively appraises a 'traumatic' event and the related conceptual instability.

Reeves (2011) suggests that certain symptoms of PTSD as described in DSM IV-TR (such as hyper-vigilance) (APA, 2000) are not always noticeable to a soldier's colleagues when in a combat zone. Instead, symptoms became a problem only when the soldier wants to reintegrate to civilian life; being hyper-vigilant might be life-saving at the front line but could be perceived as paranoia in a civilian supermarket for example. This destabilises the concepts of categorisation and diagnosis as it suggests that the environment is a key contributor to whether or not a person is classified as having 'a problem,' which may subsequently affect their subjective experience of distress. This also has consequences for how others view veterans; an identity aligned with PTSD might be located more within a discourse of a suffering war hero, whereas one aligned with excessive alcohol consumption may be more negatively perceived.

**Men's help-seeking**

The current research on help seeking is also furthered by the findings of this study. Wessely (2003) found that amongst the military, seeking help for a mental health problem was associated with weakness; this can also be found in constructions in the focus groups. It is interesting that constructions of what it means to be in the army
position soldiers as both the creators of a system that does not allow help seeking as well as its victims. However, it could also be argued that the culture that prevents seeking help is encouraged at an organisational level. This is supported by research which found that alcohol misuse can be viewed as positive as it aids camaraderie and thus cohesion amongst troops (O'Brien, Hunt & Hart 2005). Discourses in the focus groups suggest that cohesion in the unit is key to minimising distress, which means that it could be argued that empowering veterans to own experiences of distress might threaten this cohesion, and therefore might be both impossible and undesirable.

The findings of this study support the idea that the way in which men express experiences of distress differs significantly from how psychological services are designed to identify them. For men in the military, the 'extreme masculinity' represented by this culture means that they are even more unable to seek help, or indeed admit to themselves if they have a problem. The difficulty with this is that in some ways, this cohesive, extreme version of masculinity serves a protective function for soldiers both in practical terms as well as psychologically. That silencing distress may also inadvertently serve organisational agendas by minimising the discourses around military trauma makes this position still harder to challenge.

Reciprocity of help giving has also been found as central to men's ability to seek help (Wills & DePaulo, 1991). This could be evidence to support the TRiM approach mentioned earlier, where people experiencing problems are initially identified and supported by a peer. Addis & Mahalik comment that 'any strategy that increases the perception of normativeness for particular problems should be effective in facilitating help seeking,' (p12) This is clearly a challenge in the military where
experiences of distress are non-normative, and considering that cohesion is such an
important factor in the military, this supports the TRiM approach still further through
the potential to challenge this perception of normativeness.

The danger of labels

This research also contributes to raising wider questions about the benefits and risks
associated with classifying and labelling distress. These are important issues outside
the sphere of military trauma, or indeed trauma in general. For example,
understanding what we might call psychosis as more of an ‘unusual experience’ or
indeed indicative of spiritual wisdom will depend on your cultural vantage point.
Whilst the Ayahuasca ritual (practised amongst certain shamans of the Peruvian
Amazon, and involving drinking a cocktail of psychoactive ingredients in order to
achieve greater spiritual awareness through hallucinations) might not seem out of
place there, in the UK such a practice is likely to precipitate police involvement, a
psychiatric assessment and questions about substance misuse.

It is interesting to link this idea of classification and its alignment with the medical
model with the rise of psychiatry as a discipline. It could be argued that this
construction of classifying mental disorders within psychiatry was a product of the
historical context of the later part of the 19th century when the drive for classification
was evident in areas such as medicine and evolutionary theory (Boyle, 2002).
Weaknesses associated with the importance attached to classification have been
highlighted. In his 1942 essay ‘The analytical language of John Wilkins’, the writer
Jorge Luis Borges described a method of classifying animals which he claimed came
from an ancient Chinese encyclopaedia (Borges, 1965). This taxonomy divides
animals into categories such as 'suckling pigs', 'those that belong to the emperor', and those that, 'from a distance, resemble flies'. Whilst this may seem ridiculous, it raises an important point about the arbitrary nature of how we classify things, and how our cultural context may constrain this in ways we are not even aware of. Given that constructions of trauma in the focus groups and newspaper sample appear to resist static classification, often through being embedded in constructions of army identity or a critique of how veterans are treated for example, the question of how appropriate prescriptive models of distress are to understand the experiences of people in different contexts is raised again.

**Clinical implications and future research directions**

The data in this research indicate how the way in which distress is constructed makes it difficult for veterans to acknowledge this or seek help. This might locate them as a hard-to-reach group that are less likely than some other groups to access mental health services. Considering the relevance of discourses of masculinity and how this closes down opportunities to seek help, it could be argued that being a male soldier makes it doubly difficult to access help, by virtue of being both male and being a soldier. In this way, this study is located more broadly within gender issues and the legitimisation of distress and help seeking. This is important in terms of addressing the reduction of inequalities in healthcare, and suggests that a rethink in terms of understanding the problems faced by veterans and promoting their perceived ability to access help for problems such as anger or substance misuse is necessary. Additionally, there is evidence that veterans who have mental health problems during their time in the military are at higher risk of social exclusion, homelessness and involvement with the criminal justice system after leaving (Iversen et al 2005).
Whether these mental health problems are as a result of their military service or subsequent difficulties is unclear and under-researched.

I would argue that a psychologist’s mandate is to try to alleviate distress whether or not that fits into a particular diagnosis. Therefore, one responsibility is to attempt to realign understandings of mental distress to accommodate those who reject identities associated with mental ill health. This means that perhaps lower key interventions such as that offered by TRiM, which locate distress outside of a medical discourse, might be more effective at engaging hard to reach groups. This is something that could also be addressed within the context of other marginalised groups.

As UK operations in Afghanistan draw towards a close, it is possible that there may be military veterans experiencing distress who have difficulty in accessing help. Veterans need to be encouraged to seek help and to be able to have such help tailored to whatever form their distress takes, including for example practical support with issues such as employment and housing. Rothman (2008) raises the issue of ‘cultural competence’ as a vital skill to working with a particular group. Reeves (2011) conceptualises military veterans within the framework of being a particular cultural group and therefore understanding their ‘cultural framework’ is a key aspect of successful engagement and intervention with veterans. Furthering clinicians’ ‘cultural competence’ in veterans’ issues then may help contribute to better care.

**Critique of my use of discourse analysis**

It has been said that in discourse analysis, ‘there is no analytic method,’ (Potter and Wetherell, 1987 p169). Given the theoretical spirit of this methodology, it follows that any criteria for the evaluation of quality are themselves a construction which
may masquerade as objectivity, but in fact be related to dominant research ideologies, for example.

Antaki et al (2003) identify 6 ‘analytic shortcomings’ which can occur in discourse analysis. These are: ‘under-analysis through summary; under-analysis through taking sides; under-analysis through over-quotation or through isolated quotation; the circular identification of discourses and mental constructs; false survey; and analysis that consists in simply spotting features,’ (Antaki et al, 2003). Burman (2003) adds to these three further possible problems, which are ‘under-analysis through uncontested readings, under-analysis through decontextualisation and under analysis through not having a question,’ (Burman, 2003). I will now consider some of these criticisms in relation to this study.

Although this research has not only provided a ‘summary’ of the data, and indeed seeks to offer discursive context through narratively situating the discourse identified, one criticism of this study could be that insufficient attention has been paid to the overall context of the talk. This is particularly important in terms of the specific interactions between the interviewer and the participants, for example, in turn-taking. Burman (2003) raises the concern that this might lead to the decontextualisation of my own account of the analysis, in that the framing I selected could be representative of a political position, perhaps what Antaki et al (2003) might refer to as ‘taking sides.’ However, although Antaki et al are concerned that an analyst’s opinion can influence the analysis, and can consequently produce a ‘flattening of the discursive complexity’ (p10), Burman comments that it is difficult to avoid taking sides, and that ‘objectivity is not the absence of subjectivity but a particular form of it’ (p3). For this reason, a reflexive statement has been included in
this study, which includes acknowledging the historical and cultural context as well as my personal position in relation to the data. It is also important to acknowledge here that as I was using archival data, I was somewhat distanced from the process. However, I feel this enabled me to take a more objective view of the discourse, and to note the ways in which the researcher may have influenced the research, for example through her use of terms such as trauma or PTSD.

Burman (2003) also raises the importance of analysing the analytic framework, which should include a 'declared set of theoretical presuppositions' (Burman, 2003, p2) that allow others to evaluate the analysis itself. For this reason, I explore my own particular orientation to the topic area and my particular approach to discourse analysis in the introduction and method sections of this study.

As argued earlier, any evaluative criteria for a discourse analysis study is a construction. Willig (2008) describes criteria of internal coherence, rigour, transparency, reflexivity and usefulness as key aspects to consider in evaluating qualitative work. I hope this study is coherent in terms of its interconnectivity with the study that generated it (Reeves 2011). In order to maintain coherence, it has been necessary to be selective in what to include both in terms of literature and data, and I acknowledge how this contributes to the constructed nature of this research. However, a rigorous approach grounded in Willig's six stage methodology was followed which not only provides a clear structure for the work, but also enables others to have a point of reference by which to interpret it as a construction in itself. I hope I have taken a reflexive approach throughout, acknowledging my unique position and history as fundamental to the construction of this study, and what this has both enabled and disabled. Lastly, with regard to usefulness, I hope that my study
has gone some way to illuminating further what seems to be a significant gap between the culturally available labels used to describe distress, and the implications this has for veterans' subjective experiences.

Finally, Burman (2003) highlights Antaki et al's (2003) comment that that 'good analysis always moves convincingly back and forth between the general and the specific' (cited in Burman, p4). She takes issue with the use of the word 'convincingly,' asking the question, 'What is 'convincing' to whom, and why?' (Burman, 2003, p4) This is a key issue in the evaluation of discourse analysis studies, and mine is no exception.

**Critique of the media sampling**

One criticism of this study could be that, although they had the highest circulation figures, the newspapers selected for analysis were somewhat skewed, and their particular political context and subsequent coverage of recent conflicts might have influenced their content. Of course, other articles from other publications might have yielded different results; as acknowledged before, this study is grounded and situated in a particular historical context with particular assumptions. However, a newspaper such as The Sun has not maintained one stable political affiliation, moving from supporting Margaret Thatcher and the Tory government in the 80s towards supporting Labour in the advent of Tony Blair coming to power in 1997. However, the Mail and the Telegraph are both significantly, though not exclusively, right-wing and conservative-leaning.

As mentioned previously, I do not claim representativeness from my data selection. I aim to provide a cultural counterpoint to consider another context in which
discourses around trauma may be deployed. It could be argued that something might have been lost by integrating these two data sources. However, I would argue that a discourse analysis view of the world considers the person as constructed by and through discourse in the social world. In Foucauldian terms, it is the social world which mediates the 'reality' as experienced by individuals. If this assumption is made, then it follows that it while it is useful to consider something from an intrapersonal and interpersonal perspective, it is also important to view it from the perspective of wider culture and society. That is why the newspaper sample has something to offer the overall analysis.

It might have enhanced this study had a wider range of discourses about trauma and PTSD been accessed. This could have been achieved through analysis the accounts of families of veterans diagnosed with PTSD for example, or through focussing on how female veterans construct trauma. Further work could focus on this.
References


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Appendix 1: Information sheets and consent forms given to participants, and ethical approval granted.
Appendix 3: Information for Participants

UNIVERSITY OF
SURREY

INFORMATION FOR PARTICIPANTS

Title of Study:
A DISCOURSE ANALYSIS OF THE CONSTRUCTION OF TRAUMA
AMONGST EX-UNITED KINGDOM MILITARY PERSONNEL
INFORMATION FOR PARTICIPANTS

STUDY TITLE
A Discourse Analysis of the construction of Trauma amongst Ex-United Kingdom Military personnel.

INVITATION TO TAKE PART
Let me start by saying thank you for showing an interest in taking part in this study.

Before you decide, you need to know why the research is being done and what you would be asked to do.

Please read the following information carefully and talk to others about the study if you wish. Feel free to ask me any questions about the research or anything that is unclear. Take some time to think about whether you want to take part.

WHAT IS THE PURPOSE OF THE RESEARCH?
A number of people report that after seeing or being part of a traumatic event, they experience a variety of negative effects, such as feeling quite low, getting anxious and having problems sleeping. There is a lot of information in the media and in research studies that shows that people in the military often take a longer time before getting help for these problems.

When researchers have looked at why this is the case, it is often said that there are problems or difficulties around asking for help. But there have been other studies that show that people in the army actually don’t think badly of people who have these effects, which suggests that helping seeking is not always difficult. This study is about what people who have been in the army think trauma means and their views on the effect this has.

WHO IS DOING THIS RESEARCH?
My name is Pamela Reeves and I am currently doing my doctorate in clinical psychology at the University of Surrey. I am doing this study as part of the requirements for my doctorate.
INFORMATION FOR PARTICIPANTS

WHY HAVE I BEEN INVITED TO TAKE PART?
I am looking for men and women over the age of 18 who have worked for the UK army. I am looking for people across different ranks to try and get a clearer picture of how these issues are discussed in different places in the organisation.
You have been identified as someone who meets those requirements and you live in the Hampshire/Wiltshire area during the time of the study.
I am hoping to speak to 4 groups of people, each with between 4 and 8 people, who all meet these criteria.
The groups will either be all men or all women.

DO I HAVE TO TAKE PART?
It is entirely up to you to decide if you wish to take part. I will describe the study and go through all the information in this form as well as be available to answer any other questions you may have.
When you have had a chance to think about what we have talked about and the information in this form, you can decide if you wish to take part.
If you decide to go ahead, you will need to sign a consent form to say that you are happy to proceed.
You will be free to withdraw at any time without having to give a reason.
INFORMATION FOR PARTICIPANTS

WHAT WILL I BE ASKED TO DO?
You will meet with me and between 3 and 7 other people who were of a similar rank to yourself. I am hoping to have these meetings very locally, so that no-one has to travel very far. We will most likely meet in places such as a village hall, town hall or a local British Legion club.

These groups will be set up when I have a few people who are willing to take part, so the details of when and where will be confirmed when I have some participants, but you would be given lots of notice.

I will lead a discussion between the group and we will cover a range of topics such as what people mean by the word “trauma” and your views about how this might affect people or not. We will talk about whether or not you think people should ask for help and whether this is a problem or not. You will not be expected to share personal information if you do not wish to. You do not have to have experienced any traumatic event to take part in the research. I do not anticipate that anyone will find the conversation embarrassing or distressing in any way, but if this should happen, I will be able to give you information about where to get support.

The group discussion should take about an hour and you would not have to attend more than once.

As this is not a physical exercise, there are no real restrictions on your lifestyle beforehand, although it would be preferred if you were not under the influence of alcohol at the time of the group discussion.

At the end of the study you can have a copy of the findings. If you want to, please let me know.

WHAT ARE THE BENEFITS OF TAKING PART?
The study will not benefit you directly, but the information may be of benefit in helping us understand reactions to trauma and asking for help.

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?
There are very few risks in taking part in this project. It is possible that you may feel uncomfortable at times during the discussion, however you will not need to talk about your own experiences directly and you will not have to disclose anything you don’t wish to.

There is also the possibility that you find the discussion upsetting you. If this is the case, I could signpost you to further help.
INFORMATION FOR PARTICIPANTS

CAN I WITHDRAW FROM THE RESEARCH AND WHAT WILL HAPPEN IF I DON'T WANT TO CARRY ON?
You can withdraw from the research without having to give a reason.

ARE THERE ANY EXPENSES AND PAYMENTS WHICH I WILL GET?
You would be paid for any travel expenses that you incur to get to the discussion, up to £10.00.

WILL MY RECORDS BE KEPT CONFIDENTIAL?
I will be recording the discussion on a digital recorder. The plan is to transcribe the recording into a typed format as quickly as possible. The original recording will then be stored at the university in locked storage for 10 years. The transcribed data will then be totally anonymised and will be kept on a password protected laptop and memory stick.

The consent forms will be stored separately and also locked at the university for 10 years.

This lengthy storage is so that if other scientists ever dispute my findings, they have time to go through the data and check whether I have been honest and accurate in my reporting.

I am unlikely to need to contact you for further research relating to this project, however, it may be that I use the same information that I collect for other projects in the future.

a. Who will have access to the records and resulting data?

During the project, the only people who will have access to the data are myself and my two supervisors for this research. Dr Hacker-Hughes is head of psychology for the MoD and Dr Simonds is a research tutor at the University of Surrey. They will only have access to the anonymised data.

I will also be using a transcriber to type up the interviews. This person will have to sign a confidentiality agreement and will be chosen from out of the local area, so that there is a limited chance that they will recognise anyone's voice. If they did recognise anyone's voice, they would be expected as part of the confidentiality agreement to stop transcribing.
INFORMATION FOR PARTICIPANTS

WHO IS ORGANISING AND FUNDING THE RESEARCH?
The research is being overseen by the University of Surrey as part of my doctoral research. They have provided me with a small budget for this research although other funding will be provided by myself.

WHAT WILL HAPPEN TO THE RESULTS OF THIS STUDY?
I hope to publish the results of the study in an academic journal. It may be possible to publish more than one paper from this study, but this will depend on the data collected.
You would never be personally identifiable in any publication.
If I am unable to publish the study in a journal then it is likely that I will place the abstract on a database called "Dissertation Abstracts International". The final research project for the university will be bound and be available through the university library.
I would also make a copy of the research available for the McD.
If you would like a copy of this, I would be happy to send you one.

WHO HAS REVIEWED THE STUDY?
All research is looked at by an independent group of people, called a "Research and Ethics Committee" which has been set up to protect your safety, rights, well-being and dignity. This study has been reviewed and given a favourable opinion by the Faculty of Arts and Human Sciences Research Ethics Committee at the University of Surrey.
FURTHER INFORMATION, QUESTIONS OR COMPLAINTS.
As the chief investigator for this project, I will be available to answer any questions you may have about this research. Please contact me at any of the following contact points, however it is likely to be most efficient to contact me either on my mobile or my email address.

In the case of a complaint, in the first instance please contact myself at the below details.

Name: Pamela Reeves
Post Title: Trainee Clinical Psychologist
University Address: PsychD Clinical Psychology
Department of Psychology
Faculty of Arts and Human Sciences
AB Building
Guildford
Surrey
GU2 7XH

E-mail: armystudy@hotmail.co.uk

If however, I cannot answer the questions or am the subject of your complaint, please contact the Chair of the Faculty of Arts and Human Sciences Ethics Committee, Dr Adrian Coyle.

Email: A.Coyle@surrey.ac.uk
Appendix 4: Consent Form

CONSENT FORM
FOR PARTICIPANTS IN RESEARCH STUDIES

Title of Study:
A DISCOURSE ANALYSIS OF THE CONSTRUCTION OF TRAUMA AMONGST
EX-UNITED KINGDOM MILITARY PERSONNEL

- The nature, aims and risks of the research have been explained to me. I have read
  and understood the information for participants and understand what is expected
  of me. All my questions have been answered fully to my satisfaction.

- I understand that if I decide at any time during the research that I no longer wish to
  participate in this project, I can notify the researchers involved and withdraw from it
  immediately without having to give a reason.

- I consent to the processing of my personal information for the purposes of the
  research study. I understand that such information will be treated as strictly
  confidential and handled in accordance with the provisions of the Data Protection

- I agree to volunteer as a participant for the study described in the information sheet
  and give full consent.

- This consent is specific to the particular study described in the Information for
  Participants attached and shall not be taken to imply my consent to participate
  in any subsequent study or deviation from that detailed here.

Participant's Statement:

I__________________________

agree that the research project named above has been explained to me to my
satisfaction and I agree to take part in the study. I have read both the notes written
above and the information for participants about the project, and understand what
the research study involves.

I__________________________

would like to or would not like to be in receipt of a full and final copy of the research
project.

Signed ____________________________ Date ____________

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MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix 3: Ethical documentation

Chair's Action

Ref: 481-PSY-10
Name of Student: PAMELA REEVES
Title of Project: A Discourse Analysis of the construction of Trauma amongst Ex-United Kingdom Military personnel
Supervisor: Dr Laura Simonds
Date of submission: 15th July 2010
Date of re-submission:

The above Project has been submitted to the FAHS Ethics Committee.

Favourable ethical approval has now been granted.

Signed: 

Dr. Adrian Coyle
Chair

Dated: 29th July 2010
Dear Laura

Provided consent is obtained from the original participants for their data to be used in a further study by another researcher and provided the second trainee commits to following standard procedures re confidentiality and data security, this study does not require further ethical consideration by the Faculty Ethics Committee because no new major ethical issues are raised. However, the draft consent form that you attached needs to include space for the researcher to sign it as well as the participant.

If participants do not respond within a specified time, it is acceptable to infer consent, provided that checks have been made to ensure that up-to-date contact details are held for all participants. More than one attempt should be made to contact any non-responders.

Adrian
Consent Form

During 2011 I took part in a research study entitled 'A Thematic Analysis of how combat-related trauma is currently understood and made sense of amongst British Army veterans' conducted by Pamela Reeves as part of her doctoral training in clinical psychology at the University of Surrey.

At the time I consented to my data being used for this study.

I now give consent for my data to be used in follow-up studies conducted by clinical psychology trainees at the University of Surrey and supervised by Pamela Reeves.

I understand that the data I have provided has been anonymised and that the trainee clinical psychologists will not be able to identify who I am.

I understand that no other researcher will have access to my name or contact details.

I understand that I will not be identifiable in any publications arising from this research.

Signature of participant:
Print Name:
Date:

Signature of researcher – Pamela Reeves:
Date:
Appendix 4: Willig’s (2008) 6 stage analysis process

Stage 1 – Discursive Constructions

In looking at the data sources, the first task is to identify instances of constructions of trauma. At this point it should be stressed that this does not mean looking for the use of the word itself, but more for instances of meaning (and it is of course acknowledged here the influence of me as the researcher in this process). As Willig (2008) notes, even if there is no direct reference to the object itself, the way in which it is talked around may offer important insights into how it is constructed across contexts. I refer to these instances of talk as ‘discourses’ (Parker, 1992), although I acknowledge that different analysts use different terms which are accompanied by other theoretical assumptions (Antaki et al, 2003).

The focus group texts and newspaper article sample were closely read and re-read and instances of constructions of trauma were identified. From this it became clear that the construction of other objects, for example ‘masculinity’ and ‘the army’ had an important effect on how trauma itself was or could be constructed.

Stage 2 – Discourse

The second task is to explore differences between constructions. This involves examining how the different constructions are part of wider discourses, for example, if someone talked about being ‘diagnosed’ with trauma, this is located within a wider medical discourse around what trauma means.
Differences between constructions of trauma were noted, and attempts were made to locate these within both the historical and cultural context.

Stage 3 – Action Orientation

This stage involves looking more closely at how constructions are deployed and what the function of this might be. It is important to bear in mind here that the text within discourse analysis is seen as a form of social action (Willig, 2001).

Questions here might include: What is gained by portraying trauma or suffering from trauma in a specific way? How does it relate to wider understandings of the acceptability of suffering from trauma?

Stage 4 – Positionings

This stage of the analysis explored how the constructions identified made certain positions available to writers or speakers, and how this related to managing their identities successfully. The positioning stage looks at how the use of differing discourses within the text allows people (or institutions) to take up or avoid different subject positions. For example, a veteran might claim a subject position of strength by employing a discourse which constructs trauma as weakness, and placing himself outside of it.

Stage 5 – Practice

This stage considers how constructions and subject positions allow or disallow opportunities for action. As Willig describes it ‘...certain practices become legitimate forms of behaviour from within particular discourses. Such practices, in turn, reproduce the discourses which legitimate them. In this way, speaking and doing
support one another in the construction of subjects and objects’ (Willig, 2008, p111). Discourses and subject positions make available certain ways of being and saying and limit others, therefore this stage is vital in beginning to explore the power dynamics that may be inherent within discourse.

This stage sought to investigate and highlight the implications of the varying availability of different subject positions both for the individual and for society's understandings of trauma. The way in which this opened or closed opportunities for individuals was examined.

*Stage 6 – Subjectivity*

As established in the previous stages, discourses construct social realities. It is therefore important at this stage to consider what it means to occupy particular subject positions in terms of the subjective experience (i.e. what can be felt and thought) that this makes possible for people (or institutions or society). During this stage, the relationship between the positions available and the experience of those individuals is examined and explored.
Appendix 5: *Extract from transcript of non-officer focus group with analysis shown*

It is difficult to demonstrate the analytic process in the form of an appendix, due to the refining of ideas through several re-readings of the text. However, these appendices give a flavour of this process, demonstrating the work in progress.

The talk was colour coded according to constructions of trauma that could be linked. Some of these were embedded within other constructions, such as what it means to be in the army. Several re-readings of the text further illuminated this and potential functions of the constructions were considered in accordance with Willig's (2008) six stage criteria. The later stages of the analysis of the function of some of the constructions are shown in comments at the side of the transcript. Again, these were refined through further readings until the final analysis was reached. Broadly speaking, the colour codes reflect stages 1-2 of the 6 stages, and the comments section show the beginnings of stages 4-6.

Although the colour codes I have used do not necessarily reflect discrete constructions, they show how constructions are linked to later points in the talk.
Colour codes

**Turquoise**: Trauma constructed from vantage point of present looking back.

**Grey**: Trauma constructed as embedded within ‘coping’ and getting on with the job.

**Teal**: Trauma constructed as something that isolates people (embedded within constructions of what it means to be in the army, part of a discourse of ‘not talking.’)

**Pink**: Trauma constructed as something exciting, embedded in construction of cohesion within a unit or group being essential to survival.

**Red**: Trauma constructed as just being part of the job

**Light green**: Construction of army as a unified force which requires soldiers to fit in

**Yellow**: Trauma constructed as ‘something’ but defined in terms of how it ‘looks’/what it’s not.

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OK, so you’ve all been in pretty rough places! LAUGHS OK, so I guess I wanted to start by exploring a bit about what people think the word ‘trauma’ actually means. What does it mean to you when it’s used? And it’s used a lot, what do you think it actually means to you?

Soldier 2 – Physical or mental, there’s two types of trauma. I suppose if we’re talking about mental trauma, it’s an inability to cope, or an ability to cope, it depends which way you look at it. Trauma can be physical and mental. Mental trauma is an inability to cope...
Soldier 4 – To me it’s about taking something away that, whether it’s at the time or later, some of the struggle I go through at the moment is because my trauma wasn’t as I picture guys in Afghanistan or Iraq or the Falklands, but it was long, there were incidents happened, but more mentally than anything else, and then something happens to your egos that flick that up and made me realise now that I’m having to deal with that trauma. And dealing with trauma for me in a, when I was in Northern Ireland it was very combative, but non combative in the same sense, struggle even more because I don’t think you should be suffering it. But I look at it a lot more now, so I do think trauma’s that bit that is disturbing you in a wider way and then you know I’ve been unable to cope with it or tried to find a way to cope

Soldier 1 – For me it’s just an unwelcome event that you really, you don’t feel you’ve got any control over. I mean when (daughter) got ill, if I can use that, I kept going into work, I didn’t take any time off at all, and what I used to do, when she was really bad, she was in hospital in (place in Germany) for a while and she was on drips and things and, but I would go to work during the day and my wife would go to hospital through the day, and then I’d finish work and go to the hospital and she’d go home and then I’d stay till sort of 11, midnight, whatever and then I’d go home, but then I’d get up the next day and go to work. And that’s what, I thought I was coping really well, I thought I was you know, until there were a couple of civil servant women came up to me one day and they went (name), for God’s sake, iron your stuff, get a haircut, have a shave, you look like shit! And I was, and nobody, because everybody knew what I was going through, nobody would come here and actually no one in the military would actually, and you would have thought they would but they didn’t, because I was (career position) at the time and I used to walk in there and you’d see people scurry away and they would just think he’s having a hard time, leave him be, you know. And I did, I got home
that night, had a look in the mirror and thought, you know what, you do, you look like crap. And I went and got my hair cut the next day, sorted all my kit out and I was fine after that. But it took that not realising actually I was, I thought I was coping really well but I wasn't you know, and that was just, it wasn't trauma, well it was trauma but it was stress, you know it was the stress of it all. Trauma is an unwelcome event in which you have no control. People in the military didn't talk about how I was when I was distressed. People in the military would avoid talking to me when I was distressed.

Soldier 4 -- But no one, I can't remember, that's what I was just saying about the twenty years nearly I've been out, because I never know if there is. I mean obviously the support network once you're out, the British Legion are very good, you can, you know, because I had my injuries afterwards and they have been very good, but at the time there just doesn’t seem for it to be there, it’s just, it’s, you know, you go back in the bar at the end of the night and you talk about whatever happened, or laugh about whatever happened or whatever you saw, and it wasn’t a trauma, it was an adventure for that day, something decent happened today, you know I got shot at, or you know something large happened outside but

Soldier 1 -- Actually that’s the thing isn’t, the bar was always used in the evening time. We had a lad killed in (place in Germany?) on the range on day, a 66 came in blind and when the armour opened it to check it, it went off inside the armoury and a young lad got killed, and straight away they said, right we'll open up the bar, and the guys all went off you know to the bar and had a drink and everything else. That was the same night that they bombed JHQ, because that all kicked off later on, I was on the, duty officer at the time. Yeah and I did think even then it was strange that that was the, you know OK open the bar early, let the guys go in and have a drink.
Soldier 4 - I can never remember any of my you know corporals or sergeants, staff sergeants, ever saying are you alright? Never. I can’t recall all that. Officers never asked if you were ok.

Why do you think that is, why are ...?

Soldier 4 - I think it was, whether it was just part of the job, part of the set up that you’re in ... Incidents are part of the job.

Soldier 2 - I think myself, you know, I joined, I don’t know if you were in the ordnance, I was in the ordnance when I joined the Army ...

The what?

Soldier 2 - The ROC, I think it’s called logistical now. But I was in the ordnance to start with which given an engineering task as it happens, you know the old bull fuel sort of emergency systems. And I was thoroughly fed up, you know I said before about being excited about being in the Forces, and it was like a trade and I wasn’t happy at all, so I transferred to Commando Brigade after that and that’s when I became who I was you know, I thought this is where it’s at. The thing is you’re surrounded by super motivated, very fit people aren’t you? So the only time you’re going to think that sort of impinged upon your ability to be motivated tends to be locked behind closed doors I think. Even down to like, going back to in the ordnance and basic training, this is how you go sick in the Army, you have to go to the sick parade do you know what I mean? (others laughing) They basically...
didn't want you to go sick, it was such a rigmarole to be caught sick that you just didn’t go sick. Soldiers around you are always super fit and motivated. Being sick in any way is unacceptable in the army.

Soldier 1 – Yeah, number one dress (talk together 22.47)

Sorry just explain that to me, if you were ill, you had to do

Soldier 1 – You had to wear your dress uniform, so you had to wear dress uniform and carry enough, sort of 48 hours’ worth of clothing and your wash kit and everything else, in case you went to hospital. But that, and you had to report at 7 o’clock in the morning or whatever it was … Army procedures make “being sick” very difficult, so easier not to be sick.

Soldier 2 – That’s it, yeah, if it’s …

Soldier 1 – It was really difficult, and actually most of the time you just went, you know what (al talking and laughing) just sort it … (?23.22) Easier not to be sick in the army than go through the procedures.

Soldier 2 – But it was designed to root out malingerers, because there was an element of malingering in the Army, I mean I suppose that goes back to National Service and everything like that. But you’re fighting, a bit like two sides aren’t you, the bureaucracy, the military, I always found, I think I was perfectly placed because I was in the ordnance in what I called like ‘peace time’ when I went to the commander unit it was like being in a war, even though there was no war on! Everybody was at the triple you know, it’s like that isn’t it? And it’s
like the peace time Army and the war time Army are two different things, and that’s where the crossover happens sometimes, you know moving from one, you know into conflict and out, isn’t it? I found anyway. Procedures around sickness are in place to deal with malingering. Malingering is something the army is aware of from the historical problems of national service. There are two different armies - a peace time army and a war time army.

What do you mean by that?

Soldier 2 – It’s almost like, I used to get told this actually, this is in the commando side, they’d said to the likes of me, because they must know, I used to say they’re very good management aren’t they, they’ve been doing this for thousand years, and you’re allowed to down hills and you want to do it. And we used to say there’s two types of soldier, there’s like a peace time soldier, and it’s all hunky-dory and everything’s you know, it’s a good job, a good career, but we rise to the occasion when it happens. But there’s other blokes who are hostilities only, and apparently I fell into that category, which I didn’t know, which I wasn’t too happy about to be honest, but I thought I was just like everybody else. But that’s, and that’s how they do categorise it. And it’s, I was told that you are the type, you’ll have more difficulty because in peace time you’ll be, and I thought they’ve got this all wrong. And I thought they were so wrong because you know … But my corps sergeant(24.56) said no you are, you’re one of them. There are two types of soldiers - a soldier who thrives in peace time and a soldier who thrives in war time.

Soldier 1 – Because there are people who join for the excitement and they want to go, volunteer for every sort of … I volunteered for things and I did everything they wanted me to do, but I never joined with that sense of excitement of wanting to go, to me it was a job and
you know I obviously joined because I was doing business studies or something at college because my dad wanted to go to college because he hadn’t, and actually I didn’t really like it, I just wanted to finish school … There is a type of soldier for whom the army is a job and there is no excitement and no desire for conflict.

Soldier 2 – A bit of adventure really.

Soldier 1 – Yeah, I was happy with the job, I was never particularly looking to go off and find a conflict anyway.

Soldier 4 – I volunteered for …

Soldier 1 – I did volunteer, I volunteered for the Gulf War but I didn’t, because we weren’t going to go, so I shifted you know, I had Repro experience and they were looking for some Repro commanders and so I did that, whereas I was actually on JAMAS and the JAMAS they weren’t going to take down there. But no I didn’t, there were some guys who yeah, that was all they wanted to do was be away in conflict somewhere. Some soldiers thrive on being in a conflict and want to be there.

Soldier 4 – Well I volunteered, I mean I didn’t go ?(26.04) go to the Falklands because I was already fresh from Northern Ireland, I didn’t go the Gulf or the operation in Berlin, but it wasn’t about volunteering for war, it was about you knew your mates were there.

Soldier 3 – Yeah
Soldier 4 – And it really was about that, it was oh (name) is there or (name) is there, and it was about wanting to be with them, rather than wanting to go gung ho over the top, shooting a rifle, because I don’t think I’ve ever been gung ho going over the top shooting a rifle, I did some dopey things in Ireland. But it is about the people you mix with. Because the one thing the military do for you is within your regiment you’ve got, you know even within your own troop, you’ve got your own section so you’ll, you know A Section will go up against B Section for having a romp in the afternoon, then you’ve got 1 troop versus 2 troop, so you’ve got the inter conflict there. Then you’ve got the you know inter squadron, so you’ve got this squadron versus that squadron, that regiment versus that, and then this corps versus … And you’re led all along always to be in, you know, whatever, you know wherever you might, so it will be the Army against the Navy, so no matter what level it was at, it was always, you were always opposing somebody, or always in an opposed group with somebody, which I think was the biggest shock for me coming into …

Comment [324]: Cohesion and being part of the squad is constructed as very important – also serves an organisational function in that means fighting force effective? Also means standing out is further removed as a possibility.

Soldier 1 – You have real loyalties don’t you? I mean I’ve always worked my career, I never looked for promotion, I mean it came but I worked on the basis that you’re always loyal to those immediately below you, because they’re the ones that sort of put you there. So my loyalties were always to, if it was the section, initially it was the lance corporal, it was always my half section, then when you get your call it was you know it’s my troop, I was loyal to them, or your detachment or whoever it is. As long as they knew that you would do the best for them, they would always do their best for you. And it was, it was just, that’s the way it worked. And actually that’s what I miss, that’s what I miss more than anything I think, working in somewhere like probation, they just don’t have that ethos, they don’t have that loyalty to the sort of immediate teams, and then it goes out from there on. So like you were

Comment [325]: Successful army identity aligned with loyalty at all levels. People do their best for each other and that’s how everybody gets by – link to not being able to stand out in any way, for example by experiencing trauma. The unit is necessary for survival.
saying you might get to Army/Navy level and you’d be loyal to the Army if you were in the Army, but the moment it was tri services versus someone else, you’d be loyal to the tri services, you know it just steps up.

How do you make sense for you, because you all seem to be nodding about that, that there is a sense in which there’s a community that you belong to in the military, and you all seem to feel that that’s something you miss. And yet you’ve also said that you never talk about the crap stuff. How do you make sense of that? What are these friendships based on?

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Soldier 3 – I’ll tell you, when I was in Northern Ireland when I was about, I must have been about eighteen, I’d been there about a year or so, and my first wife who went off to Dublin for the weekend, I came back and I got in a lot of crap about that! But a guy in our room, a guy called [name] he went off, he was from Dublin, and the only reason he was there so he could go and see his grandmother, and on the way back he got executed, well virtually, well he was executed in Dundork on the way back, he was caught and killed. We didn’t get nobody ever spoke to us about it. I mean he wasn’t a friend, but he was in the room as us so we knew him. And it’s funny because I actually blanked that out, and it was only, I suppose when the actual conflict was finishing they came out and I’d completely forgotten about him, and I came out and they had a list of all the people that died, and I saw his name on it, and I thought, you know and he used to sleep in the next bed to me, and it’s strange, you just blanked it out, you just never thought of him again.

Soldier 4 – Mm and I think as well within the section and the way they breed that is you don’t want to be seen as the weak one in the section with a problem because nobody looks like...
you've got a problem, you're going out there, you're doing what you do and you just don't. You, I never gave the impression that I needed to look scared in whatever I was doing, whether it was ground search, whether it was you know getting shot at down in (place) or whatever. You just don't have that, you just don't let anyone know because you know at the time you don't think of it anyway, you just get on with the job, but after the point it's 7th (30.10) regiment, but you can't be seen as or made ... I can only think that everyone else is thinking the same because no one ever showed fear in anything because that was you know ... If you have a problem you are seen as weak. Need to get on with the job. Don't let anyone know that you are scared. No-one ever showed fear.

Discourse analysis of newspaper article.

The below article was approached using the same method as described above in accordance with Willig's (2008) six stage criteria.

Red: Constructions embedded within a discourse of extreme violence

Grey: Trauma constructed in terms of comparison with physical injuries

Yellow: Constructions of national shame at 'neglect' of distress

Pink: Soldiers constructed as superhuman in terms of suffering

Dark green: Trauma constructed within context of returning to civilian life
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