Identity and veteran health:

Considerations of context, culture, and change

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Abstract

Veterans often have poor physical, psychological, and social health outcomes compared with civilians, including elevated rates of substance abuse, self-harm, and suicidality. These outcomes are exacerbated by the reluctance of military personnel and veterans to engage with healthcare services, and a lack of consensus about optimal rehabilitation and transition strategies. In addition, the extent to which these outcomes and behaviours relate to identity is not clear. This investigation aimed to explore the extent to which identity and agency (collectively comprising 'sense of self') impacted the health and health behaviours of serving soldiers undergoing rehabilitation and transition. To achieve this, a qualitative thematic and contextual approach, positioned between non-relativist social constructivism and critical realism, was employed. Thirteen Australian high-risk combat soldiers undergoing rehabilitation took part in two semi-structured recorded interviews. These yielded approximately 50 hours of primary interview data, which were then transcribed, coded and analysed using psychodynamic object relations theory. This theory was developed by scholars such as Donald Winnicott and Ronald Fairbairn, who shared several features: they were veterans, held qualifications in medicine and psychoanalysis, and many had personal histories of early separation from their family. These experiences attuned them to primary group relationships (wherein mutual dependence is necessary for collective survival). As such, many of the concepts embedded with object relations theory had particular relevance to the experiences of current participants.

Analysis yielded four data-driven papers that provide insight into the development, defense, loss, and redevelopment of participants' identity, and the extent to which these influenced health and health behaviours. The first paper critically examines identity developed in combat and highlights the mechanisms that undermine such identity. The second documents the meaning soldiers attach to health and how these impact on health behaviours including primary healthcare utilisation. The third explores the extent to which identity loss related to participants' negative health behaviours, including self-harm and suicidal ideation. The final chapter highlights the utility of exploring values in military and veteran populations and, in doing so, provides insight into the process of individuation and separation evident as some participants came to terms with their loss.

Overall, the speech of participants, their reported behaviours, coping mechanisms, and relating styles, paralleled those most typically associated with adolescence. Although strong primary relationships were critical to mission success, extremely adaptive in

context, and thereby highly valued, it appeared that when particular behaviours and perceptions of self and others were no longer available, a crisis of identity ensued. This crisis triggered negative emotional and behavioural consequences in all participants, and for some it also brought about a degree of maturity previously unknown to them. Findings and analysis have theoretical, policy, and clinical implications. They suggest that rehabilitation and transition may be usefully understood as a stage of separation and individuation, which points to the need for psychologically-framed primary healthcare services that build upon soldiers' perceptions of health, articulation of need, and what they value, especially by way of interventions that address issues of identity and agency.

Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint award of this degree.

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Paula Anne Dabovich

Signed: Date:

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Dedication

For my beloved children Elizabeth and Amelia Barter.

Overview

This thesis commences with a review of the literature that outlines what is known about veteran health and health behaviours, along with the conditions leading up to, and including, the experience of military to civilian transition. Following this review, Chapter 2 outlines the theoretical lens through which the research is viewed, and is followed by observations of the theoretical gap that exists in the field of veteran health. The methodology used in the research is then described in detail that could not be included in the individual papers, here presented as the following chapters. Each paper is prefaced by a linking page to help contextualise each as a chapter and cohere the narrative.

Chapter 3 documents the ways that participants establish their identity and explores their own observations of how such an identity becomes temporally and contextually problematic. Chapter 4 outlines the meanings that participants attach to health and the implications of these as they relate behaviours such as help-seeking. In Chapter 5, the extent to which identity loss contributed to suffering and negative health behaviours (including self-harm and suicide) is documented. Chapter 6 explores the ways in which identity is reformulated after serious wounds and injuries and highlights the utility of exploring values in military and veteran populations. Finally, in Chapter 7, analysis, discussion, and implications are offered through an object relations psychodynamic lens, to synthesise and integrate the findings.

Introduction: What is it all about?

1.1 Context of the research

There are numerous unresolved issues in relation to veteran health which are evidenced by the suffering and ill health many veterans continue to experience, and by the challenges faced by clinicians working with this population. There also remains a lack of broad theoretical foundation within the field of military health specifically for understanding veterans' adaptations during rehabilitation and transition, and a lack of consensus regarding optimal support strategies to underpin these processes. This thesis offers a qualitative account of how high-risk combat soldiers (such as those who participate in direct lethal action) talk about themselves in relation to others, and over time, as they rehabilitate from serious wounds, injury, and illnesses. The account documents the degree to which changed self-constructs impact health-related behaviour in this population and in doing so, offers perspective and insight into the criticality of self and relational dynamics that in turn, impact health and wellbeing.

The project was inspired by observations of the investigator when working with Australian high-risk combat soldiers. This was at a time when the Australian Defence Force (ADF) was experiencing the highest number casualties since the Vietnam War, as a direct consequence of the ADF's involvement in the Middle Eastern area of operations. Although the ADF provided world-class healthcare services to its members at the time, it was simultaneously observed that many soldiers appeared relatively disengaged with the care and expertise offered to them: they were observed to have difficulty communicating (and perhaps identifying) their needs, and behaviourally many presented as both non-initiating on one hand, and self-destructive on the other—a phenomenon layered with clear displays of anger and distress. These behaviours and emotions sat in stark contrast to the high degree of agency, motivation, and wellbeing otherwise observed in their population pre-injury.

These observations of behaviours and emotions were widely shared by clinicians, personnel officers, commanders and families alike; all found them difficult to comprehend, which in turn, impacted their felt ability to provide adequate support. On private reflection, the investigator considered the potential negative short and long-term implications of the observed phenomena on both military capability, and on those impacted. It was these observations and reflections, driven by the need to maintain capability for the collective and improve outcomes for the individual that foreshadowed this study.

This chapter provides a setting for the research by outlining what is understood about the health and health behaviours of military personnel and veterans, especially during rehabilitation and transition to civilian life. After establishing this context, the concept of *self* is introduced as a sum of identity and agency, and as a means of theorising veterans' health and health behaviours during rehabilitation. Further, psychodynamic object relations theory of self, as it relates to others, is introduced, along with an account of the historical precedence that connects veterans to ideas of self, psychiatry, and to public health more broadly. Finally, this chapter highlights the need to better understand the impact of shifts in veterans' sense of self on their health and health behaviours and what this research set out to achieve.

1.2 Health and health behaviour of military personnel and veterans

Military personnel are screened for physical and psychological impairment prior to enlistment, but despite this screening and the military offering no-cost healthcare to its members (McFarlane et al, 2011), there is growing international evidence that indicates many veterans experience poor health outcomes compared to civilians. While the military can be protective in relation to some conditions in the short term (McFarlane et al., 2011), the general health of veterans seems to be negatively impacted by service over time. Statistics gathered from Canada (Thompson et al., 2014a) and the United States of America (USA) (Hoerster et al., 2012) indicated that veterans of both countries reported higher levels of health problems compared to their civilian counterparts. These health problems included functional limitations, joint complications such as pain and arthritis, along with chronic conditions such as cardiovascular disease. In addition, significantly higher obesity rates have been noted in veterans compared to the civilian population. In Canada, migraines and hearing problems were elevated in veterans, and in the USA, cancer was documented as significantly more pronounced in this population (Hoerster et al., 2012; Thompson et al., 2014a). Mental health conditions were also noted as prominent in veterans across both countries, especially in terms of anxiety, and mood disorders such depression (Hoerster et al., 2012; Thompson et al., 2014a).

Although statistics regarding the general health of veterans in Australia and the United Kingdom (UK) are not as readily available, there are some indicators that many of the aforementioned conditions are common in this cohort. Of the top 20 health conditions accepted as service-related liabilities by Australian Department of Veterans' Affairs, issues of decreased function and pain (particularly related to joints), anxiety and mood disorders, along with posttraumatic stress disorder (PTSD) are similarly represented (Department of Veterans' Affairs, 2017). In addition, in 2011, those in current service were documented as having

higher lifetime prevalence rates of any mental health disorder compared to the Australian community, the most significant of which were affective disorders (McFarlane et al., 2011). Within the UK, most veterans who transition from the military on medical grounds do so because of musculoskeletal impairment, along with mental and behavioural conditions. Finally, one in every two veterans that leave the UK armed forces on medical grounds do so with more than one diagnosis (Ministry of Defence, 2017a).

Further to the physical and psychological outcomes of veterans in Canada, USA, Australia and the UK, issues of alcohol mis-use, self-harm, and suicide are significant issues amongst veterans. In the UK, heavy alcohol use has been reported as a problem for both serving and ex-serving personnel (Fear et al., 2009; Hoerster et al., 2012), and in the USA suicide rates for both these cohorts are significantly elevated (Hoge et al., 2017). In Australia, current service personnel have lower rates of alcohol use and suicide compared to civilians, but suicidal ideation is higher (McFarlane et al., 2011), as are rates of completed suicides after military to civilian transition (Australian Institute of Health and Welfare, 2017). Completed suicide rates are of particular significance for those who transition before the age of 25, or on medical grounds (Australian Institute of Health and Welfare, 2017)—a finding similarly observed in the UK (Fear et al., 2009). These findings signify that suicide is an issue of concern during military to civilian transition (Castro and Kintzle, 2014; Mansfield et al., 2011), particularly for those who are young and deemed medically unfit for service.

Veteran suicidality and self-harm are commonly associated with issues of emotional distress or reactivity, emotional numbing, and distancing (Bryan and Rudd, 2012; Lusk et al., 2015; Thompson et al., 2014b), along with mood disorders such as depression (Lusk et al., 2015), anxiety, and posttraumatic stress disorder (PTSD) (Brewin, Garnett, and Andrews, 2011). Suicide and self-harm are also associated with changes in physical health such as development of chronic pain, lost function (Lusk et al., 2015), and gastrointestinal symptoms (Thompson et al., 2014b).

Suicidality in veterans has also been linked to interpersonal issues such as negative interactions with others (Mavandadi, Rook, Newsom et al., 2013), guilt and shame (Bryan, Morrow, Etienne et al., 2013; Bryan, Ray-Sannerud, Morrow, and Etienne, 2013; Hendin, 2017; Lusk et al., 2015), along with feelings of alienation from civilian life (Brewin et al., 2011). The latter is a phenomenon shared by veterans throughout the previously cited countries, and has also been described in terms of felt social exclusion (Fear et al., 2009), and lost sense of belonging to a community (Thompson et al., 2014b). The relationship between transition from the military, felt alienation or lost sense of belonging may be manifested as

veteran homelessness. Although rates of veteran homelessness within Australia and the UK are difficult to locate in the literature or elsewhere, in Canada the USA, veterans are reported to be overrepresented in homeless populations (Fargo et al., 2012; Segaert, 2015). A recent Australian Senate Enquiry into the mental health of ADF members and veterans acknowledged a potential link between transition experiences, mental health, homelessness, and suicide, stating:

> [It is the committee's view that] Discharge is a critical time for ADF members, with the committee receiving considerable evidence that poor transition experiences are linked to poor reintegration, poor mental health outcomes, and, if left unchecked, can lead to homelessness and suicide.
>
> Department of Foreign Affairs and Trade (2016, p. 136)

This view is shared by military psychiatrists, who suggest "The socially marginal person, or one who has lost his circle of intimates to death or dispersion becomes substantially more prone to illness in all forms" (Manning, 1994, p. 2). Building on the associations between psychological, physical, and social outcomes in veterans, as well as with their challenging health behaviours, leading scholars in the field of traumatic stress have argued that "mind and body are intimately linked, in health and disease" and have called for a reconceptualisation of conditions such as PTSD as systemic illnesses, rather than psychological ones (McFarlane, 2017, p. 248). Indeed, conditions such as PTSD have been significantly associated with physical comorbidity in veterans (Andersen, Wade, Possemato et al., 2010; McLeay et al., 2017) and the general population (Glaesmer, Brähler, Gündel et al., 2011; Pacella, Hruska, and Delahanty, 2013; Pietrzak, Goldstein, Southwick et al., 2012).

The inter-relatedness of physical, mental and social health not only impacts the post-service lives of individuals, it is also critical to military capability by way of force preservation—a notion observed in the analysis of historical data:

> … in the North Africa Campaign of 1942/43 … [there was] a robust link between the numbers of physical and psychiatric casualties … as one increases, so too did the other, until eventually a unit was rendered combat ineffective by psychiatric breakdown.
>
> Wessely (2006, pp. 274-275)

A systemic approach to health is postulated to have significance in not only military populations, but in any settings where traumatic physical wounds, injury, and illnesses sustained in service can further complicate psychological, operational, and social outcomes (e.g. police and emergency services) (Bryant et al., 2010; Bryant et al., 2016; O'Donnell et al., 2009).

1.2.1 How veterans experience healthcare

Health outcomes and behaviours of veterans are reported as different to those in the civil community. One of the factors contributing to these outcomes may be that military personnel and veterans underutilise healthcare services (Currier, Holland, and Allen, 2012; Hoge et al., 2004; Jakupcak et al., 2013; Pols and Oak, 2007; Tsan et. al., 2012). The underutilisation of healthcare may be considered particularly problematic because it is widely accepted that many of the conditions noted earlier may be reduced in severity or even prevented through early intervention (Koes, Van Tulder, and Thomas, 2006; Valtonen et al., 2015).

Avoidant behaviours have been previously attributed to personal factors such as fear of stigma (e.g. Ben-Zeev et al., 2012; Blais and Renshaw, 2013; Blais, Renshaw, and Jakupcak, 2014; Gould et al., 2010; Held and Owens, 2013; Kim et al., 2011; Mittal et al., 2013), fear of losing professional and deployment opportunities (McFarlane et al., 2011) as well as unhelpful/specific personal beliefs and attitudes towards illness and care (Kim et al., 2011; Vogt, Fox, and Di Leone, 2014). However, as these data are mainly obtained by questionnaires and scales, the meaning or context behind them such as self-efficacy, real or perceived social supports, severity of illness and visibility of symptoms, and a person's belief system (especially how they define themselves and potential illnesses) (Marks et al., 2000) is little accounted for. These factors all relate to issues of identity and sense of self, and some scholars have argued:

> … the extent of compliance with the recommended treatment is intertwined not only with the character of the disease, but also with the patient's self-definition, … compliance or non-compliance is not only a means of managing symptoms but also of managing self-identity.
>
> Marks et al. (2000, p. 301)

In addition, health and the experience of healthcare are likely to be influenced by cultures and subcultures through which military personnel and veterans must navigate. Given that self-identity is an issue that conceptually impacts health and healthcare utilisation, some consideration must be given to identity, as it is forged in the military, and especially as it relates to all that is described and consequential of the above. An example of this is that the military requires its members to operate in a collective, cohesive, and relatively s*elf-less* way (Department of Defence, 2017; Ministry of Defence, 2017b; New Zealand Army, 2017; United States Army, 2017), yet recruits are drawn from, and discharged to, industrialised and democratic societies marked by individualism and *self-awareness* (Demers, 2011). A collective identity implies an orientation towards *others* or greater purpose and away from the

self, and is thus highly appropriate for the soldiering profession. Knowledge of the implications of this collective mindset on soldier healthcare behaviour is, however, scarce.

Despite the need to understand veteran health and health behaviour in the context of his or her collective and cohesive mindset, the researcher found few studies that sought to understand how military personnel experienced the healthcare they were given. The first of these examined how soldiers of the United States experienced the military medical system, with the aim to improve morale, and thereby, military capability (Jennings et al., 2005). This study produced four key insights regarding the health needs of the study population, to potentially bridge gaps in health care services and soldier satisfaction. These were: frustration regarding provider knowledge of a soldier's job; a cycle that involved depersonalisation, diagnostic delays, profiling without knowledge of soldier roles and delayed recovery; difficulty getting appointments; and leadership tensions. Although specific to the population studied, the research highlighted that military personnel exist within a complex military system bound by operational imperatives; thus, understanding their experiences at the interface of the system may hold potential to influence health outcomes and thereby, morale and capability (Jennings et al., 2005).

Medical anthropologist, Messinger, published two studies (2010a, 2010b) in relation to how soldiers perceive the care they are given after serious wounds, injury, and illnesses, especially regarding clinical provider expectations. The first of Messinger's studies contrasted a sports model of rehabilitation, focussed on the physical and functional aspects of recovery, with a model that focussed on the "individual interests and the concern of a person who has a future life to develop" (Messinger, 2010a, p. 281). The second study examined how a linear notion of time (readily adopted by both clinicians and patients at the commencement of treatment) may come to undermine a veteran's adherence to rehabilitation, their relationship with clinicians, and thereby clinical outcomes. Messinger concluded that this erosion stemmed from a gradual divergence between the two parties as to what each considered a desirable result (2010b). Although literature surrounding soldiers' experience of health is scarce, it appears that health behaviours (including seeking and adhering to medical advice) may be highly contextual and influenced by collective identification and culture within the military.

Regardless of help-seeking behaviours and the degree to which service personnel utilise and adhere to medical advice, when a service person cannot be restored to a physical or psychological status which is compatible with service, a medically-mediated discharge from the military is usually required. Sensitivity around medically-mediated discharges or transitions from the military, especially as they relate to suicide, has been previously

described. The conditions preceding these transitions, including the requirement to adapt to the military and to war, may have some impact on how transitions are experienced, and these are now outlined.

1.2.2 What is known about military transitions

1.2.2.1 Civilian to military transition: recruit training

It is well established that recruit training is designed to shape the identity of a soldier to enable national capability both domestically and internationally, and the military "consistently reinforces the notion that service personnel are fundamentally different to civilians" (Kaufman, 1982 cited in Bursnall, Kendall, and Wilcox, 2001, p. 209). How service personnel come to see themselves, especially in relation to civilians, is reflective of the military culture.

To better understand military identities, that is, how they differ from civilians, Woodward and Jenkings (2011) conducted a qualitative study with British soldiers which revealed they broadly base their identity on three themes: their fictive kinship (camaraderie), their role, and being a part of national or global events (meaning). Valuing fictive kinship and camaraderie, along with meaningful and purposeful pursuits, are indicative of collectivism, rather than individualism, with the former a key feature of military culture. A collective identity is formed when an individual develops an emotional, moral and cognitive connection to a larger community (Desai, 2010) requiring "an individual's ability to cognitively consider social entities larger than him or herself" (Lindsley et al. 1995, cited in Rosh, Offermann, and Van Diest, 2012, p. 121). Indeed, military culture is "infused with values of duty, honour, loyalty and commitment to comrades, unit and nation" (Collins, 1998 cited in Demers, 2011, p. 162).

The themes of camaraderie and working meaningfully towards something big are arguably inherent in the explicit requirement of commitment to a military career. To emphasise this point, the Regimental Sergeant Major of the Australian Army (the most senior soldier and role model) has asserted that "being a soldier is a 24/7 profession …being a soldier is a way of life" (Ashley, 2013, p. 204) while others have noted the inextricable link between a military career and identity (Haynie and Shepherd, 2011) through the blurring of work and private lives. Being a soldier, therefore, is not just a career, it is an identity.

1.2.2.2 Military to civilian transition

Despite the requirement to adopt a soldierly-identity during service, the military is neither where a person begins nor where he or she ends. Within the nations previously discussed (i.e. UK, USA, Canada, and Australia) soldiers are recruited from a largely post-industrialist individualistic culture, to which they must eventually reintegrate. While the experience of transitioning from soldier to civilian (from a collective to an individualistic context)

undoubtedly varies between individuals, some scholars have suggested it may be least disruptive if service voluntarily ends after a short period of service (i.e. when the identity of a soldier is not fully adopted) or after a very long period of service through retirement (Sugar, 2004). Other studies, however, have demonstrated that the termination of a military career (especially for those under 25 years and for those who are injured or ill) can increase the likelihood suicide (Fear et al., 2009; Australian Institute of Health and Welfare, 2017). Either way, a soldier's developed collective identity developed in service may be "in conflict with more individualistic, liberty based civic values, which embrace materialism and excessive individualism" (Demers, 2011, p. 162).

To document what was known about military to civilian transition, Shields et al. (2016) conducted a thorough review of literature that featured over 300 annotated bibliographies, as part of an increasing body of evidence concerning transition, mostly stemming from the social sciences. In synthesising the reviewed articles, the authors noted that the evidence was fragmented and uncoordinated, especially by way of language which made it difficult for them to identify themes and consider them as a part of a broader theory (Shields et al., 2016). In reviewing the cited articles, however, the current investigator identified a prevalent theme of loss.

Many articles reported on the loss of identity (Adler, Zamorski, and Britt, 2011; Brunger et al., 2013; Bursnall et al., 2001; Demers, 2011; Harris, Gringart, and Drake, 2013; Haynie and Shepherd, 2011; Higate, 2001; Vest, 2012) which included loss of role and status (Burkhart and Hogan, 2015; Hatch et al., 2013; Koenig et al., 2014). This loss of identity was associated with loss of culture, community, and camaraderie (Brunger et al., 2013; Demers, 2011; Harris et al., 2013; Wands, 2013), as well as a loss of belief or collective purpose (Barry et al., 2003; Brunger et al., 2013; Demers, 2011). Themes of identity loss, in this context, were also reported to include that of lost social support (Sigmon, 2011) and shared activity (Verey and Smith, 2012). Bursnall et al. (2001) held that:

> the magnitude of the displacement that occurs with discharge is enormous. They [military personnel] simultaneously lose their home, job, friends, role, status, income, leisure, security, identity and so forth. Every defining characteristic is altered, creating a massive displacement …the degree of loss experienced by these participants would be difficult for civilians to understand.
>
> (p. 219)

Lost identity also appeared to be associated with feelings of alienation (Demers, 2011) brought about by a gap or clash of meanings, culture and values (Ahern et al., 2015; Aloi, 2010; Bergman, Burdett, and Greenberg, 2014; Brunger et al., 2013; Demers, 2011; Hatch et

al., 2013; Kato, 2011; Koenig et al., 2014). This in turn, brought about strong emotional responses and reactivity (Aloi, 2010; Brunger et al., 2013; Elliott, 2015; Giger, 2006).

Themes of loss, such as documented in the military to civilian literature (Shields et al., 2016) are also evident historically. During WWII, for example, leaving a military unit and those with whom a soldier fought was noted to have produced anxiety (Grinker and Colleagues 1946 and Grinker and Spiegel 1945, cited in Sugar, 2003). It appears indisputable that post-service life can be psychologically challenging for many veterans, regardless of the era in which they served. Some sociological and cultural authors have provided conceptual models of transition linkages to mental health disorders (Hatch et al., 2013), general health (Castro and Kintzle, 2014), suicide (Rose, 2015), and difficulties with healthcare engagement (Koenig et al., 2014); but the intrapsychic process of this distress is unexamined.

Although loss is a significant theme in the transition literature, Shields et al. (2016) have argued that the military to civilian transition remains ill understood, which in turn, impacts the way it is managed and experienced by veterans. To address this limitation, they suggested that:

> There is a significant need for coordination of a more unified research effort. The accumulation of evidence does not appear to be linked to an acknowledged international program of research that can systematically advance knowledge in the MCT [military to civilian transition] area. Academic research is providing vital information that links determinants to specific outcomes, however there are significant gaps within this body of work that research coordination could begin to address. Without such coordination, efforts appear to be largely driven by the initiative, interests and resources of isolated departments and research groups.
>
> Shields et al. (2016, p. 135)

They further recommended that researchers should aspire to:

> … identify knowledge gaps, make propositional statements, and propose new areas for research—not merely describe MCT, but to create programs and policies that make a difference in the lives of veterans, their families, their workplaces and our communities.
>
> Shields et al.(2016, p. 128)

In addition to the above, Shields et al. (2016) also recommended coordination of language and priorities, formalised and regular opportunities for international dialogue, an agreed upon taxonomy for organising language and literature, and an agreed upon conceptual framework for approaching military to civilian transitions. Such ambition clearly requires an overarching theory that can account for the biopsychosocial elements of self, as it exists in changing occupational, social and functional contexts, over time. One such occasion that demands

consideration of all these elements of self is when an individual is required to transition from the military to civilian life, on medical grounds.

1.2.2.3 Medically mediated military to civilian transition

The very nature of excellence as a combat soldier requires extremes of commitment and fusion of identity with the collective, yet simultaneously puts each individual at risk of injury and thereby involuntary discharge. This in turn can precipitate a sudden and unexpected shift in identity, embodied by a change of medical employment category within their units, followed by movement to a rehabilitation environment, change of employment and/or medical discharge. The premature termination of a military career due to service-related wounding, injury, or illness may exacerbate identity issues surrounding transition (Bursnall et al., 2001) with the added complication of shifts in functional capacity. The difficulty and sensitivity of this period is reflected by the increased suicide rates for those who transition from the military under these circumstances (Centre for Suicide Prevention, 2014; Australian Institute of Health and Welfare, 2017). In addition, medically-mediated military to civilian transition, therefore, can involve complex and emotional perceptions of the military itself:

> Their [medical] discharge is also likely to be complicated by the anger and abandonment many discharged personnel feel towards the military … a system to which they have been fervently loyal for many years.
>
> Naughton, Sherlock, Glae and Brecht, 1998 (cited in Bursnall et al. 2001, p. 209)
>
> … personnel often perceive their discharge as a "broken promise" in the part of the military (Auster, 1992) resulting in a sense of abandonment both for personnel and for their families (Hewitt, 1992). McIver (1997) confirmed that people discharged from the military due to disability can remain stuck in resentment, anger and blame for many years.
>
> Bursnall et al. (2001,p. 209)

An understanding of the complexity and emotional impact of injury and transition for veterans is important for healthcare providers, because healthcare services are often the conduit through which wounded, injured and ill soldiers transition to civilian lives. These services, however are mostly operated by civilians who are unlikely to appreciate the complex needs of veterans (McIver 1997, cited in Bursnall et al., 2001) especially in terms of culture, community, and lost sense of belonging.

1.2.3 Conditions preceding injury-mediated transition

In the context of collective military service within a contemporary, industrialised and democratic society, understanding the psychosocial tasks of adolescence may be useful when considering the trajectory of a veteran from recruitment through to injury-mediated transition. Where Freud regarded adolescence as characterised almost solely by the maturation of sexual

organs, Erikson later considered adolescence as not only encompassing biological achievement, but also the consolidation of psychosocial development (Kroger, 1996). Writing in the mid-20th Century, Erikson suggested that adolescence lasts from the mid-to-late teen years (Kroger, 1996). Contemporary writers, however, propose that the psychosocial processes of adolescence, in post-industrial western society, may be operative up until the mid-twenties (e.g. Arnett, 2000; Ehrsensaft et. al., 2003; Hagan and Foster, 2003 cited in Schwartz, Côté, and Arnett, 2005): this period corresponds to the targeted ADF recruitment age range of 17-24 years (Broderick, 2012). The implication is that, at the point of recruitment, men and women may have relatively more malleable identities, compared to previous generations. At a time when civilian contemporaries are developing individuation and separateness from each other (Blos, 1967; Kroger, 1996), recruits are submitting their personal identities to collective identity formation, establishing strong emotional, moral, and cognitive connections to the military community. Such connection is characterised by social embeddedness, attachment, interdependence, and behavioural involvement (Ashmore, Deaux, and McLaughlin-Volpe, 2004) wherein recruits may be understood to partially arrest elements of the individual *I am* in order to be a part of the more familial *we are*. In a micro-sociological context, they may be seen to become somewhat *self-less* in the name of the greater good.

Indeed, military service is "infused with values of duty, honour, loyalty and commitment to comrades, unit and nation" (Collins, 1998 cited in Demers, 2011, p. 162). Defence forces globally utilise recruit training to build a necessarily collective community, typically by: separating recruits from existing social networks (Kelty, Woodruff, and Segal, 2010; Murphy, O'Neill, and Buys, 2001) and from larger society (Kelty, Woodruff, and Segal, 2010); stripping them of most past civilian identities (Demers, 2011; Kelty, Woodruff, and Segal, 2010; Murphy, O'Neill, and Buys, 2001) especially through common dress and bearing; immersing them in a new culture (Kelty, Woodruff, and Segal, 2010); conditioning them towards "regimentation and obedience" (Talcot et al., 1999 cited in Bursnall et al., 2001, p. 209); and, teaching them to turn off some emotions to achieve the objectives of combat (Demers, 2011). In short, the military:

> … recruits young men and women from a rich diversity of backgrounds and is charged with transforming these *individuals* into a *community* [italics added]. This community is distinguished from the civilian world in that collectively it takes an oath that binds its members to each other and their country … part of this process of community formation is shaping the way the service members see the world.
>
> Messinger (2013, p. 204)

Collectivism and the submission of parts of the self to the greater good are essential to military capability and important hallmarks of the military culture. Freud used the term *primary group* to describe hierarchal social organisations, with vertical attachment figures (such as leaders or parents) and horizontal attachment figures (such as peers or siblings), all of whom may identify (McIntosh, 1995) and depend (Manning, 1994) upon one another. The parallels between a primary family unit and a military unit have been noted by several authors (Manning, 1994; Siebold, 2007; Shils and Janowitz 1948 cited inWessely, 2006) and may be understood structurally by the hierarchical nature of the organisation and the mutual dependence for survival of its members. The affect-tionate and familial nature of the relationships within military units are evidenced by the commonly-used term *brothers-in-arms*.

1.2.3.1 Experiences during service

1.2.3.1.1 Trauma: cohering the collective

Although collectivism in the military is essential to capability, this need not inevitably lead to poor health outcomes upon separation. Other collective organisations within industrialised and democratic societies share purpose and ideology yet do not see such negative outcomes once an individual transitions out. What may make the military culture qualitatively different to such organisations is the intensity of the relationships forged through service, often under traumatic or peri-traumatic conditions, and the familial culture consequential from and created through those relationships.

Many have observed the impact trauma has on relationships, which usually begins with alterations in a person's sense of identity. For example, Erikson's life's work on identity development (Erikson 1963 cited in Kroger 1996) was inspired by observations of WWII veterans who displayed disturbance in it:

> What impressed me most was the loss in these men of a sense of identity. They knew who they were; they had a personal identity. But it was as if subjectively, their lives no longer hung together and never would again. There was a central disturbance in what I then started to call ego identity.
>
> Erikson 1963 cited in Kroger (1996, p. 15)

Erikson's observation is resonant with contemporary understandings of trauma on the individual self:

> Self-narratives are the very substance that is disrupted by trauma and loss, … a traumatic event serves to shatter an individual's closely held assumptions about the self, the external world and the relationship between the two.
>
> Haynie and Shepherd (2011, pp. 501 and 509)

Trauma may similarly impact how a person relates to others. As subjective or personal meaning and identity is disrupted, diminished, or can no longer "hang together" in a way that makes sense, people may unconsciously turn away from previous self-narratives and make greater meaning of narratives external to the self (if available) to maintain a sense of psychological organisation. It seems, when meaning or life goals that benefit the personal self are shattered, engaging in common goals for a common good may act to preserve a person's sense of being in the world.

The pro-social and positive impact of collective trauma were highlighted in a study by Poulin et al., (2009) who examined social benefit after the 9/11 terrorist attack on New York. In this three-year study of 1382 adults, it was found that 57.8% of respondents perceived social benefits after 9/11, including pro-social behaviour, religiousness, increased political engagement, and less apathy. Notably, those people who cited religiosity as a benefit two months after 9/11 were found to have greater positive affect, more life satisfaction, lower distress and less post-traumatic stress up to three years after the terrorist event. If religiosity could be understood as believing and working towards something greater than the personal-self, manifested in engaging in meaningful pursuits and thereby connecting individuals to community and each other, these pro-social benefits may be deemed positive outcomes of collective trauma. When working in a collective such as the military or an emergency service organisation, external narratives or meanings greater than the personal self are usually available and as such re-constitute a degree of self from in-here to out-there.

Movement away from the subjective self and towards a self-less (greater than or external to self) psychological construct, may be thus described as a pro-social orientation which is a necessary characteristic for those operating effectively in a collective. Whilst remaining within the collective, and whilst self is still located and experienced within it, that the sense of self may remain relatively coherent, and indeed, the shared experience of trauma may reinforce the bonds between self and others. Once the self is physically removed from the collective and once it cannot strive towards the collective goals, a disruption to identity may result.

Where collectivism and pro-social behaviour suggests less focus on self and more on common group goals and shared meanings, cohesion is the interpersonal attraction which bonds members of the collective together (Rosh et al., 2012). In a military context, cohesion may manifest through the traumatic activation of attachment needs (Ainsworth 1989, cited in Cassidy and Shaver, 2008; Salande and Perkins, 2011), and underscore strong relationships formed in the military and other emergency service organisations, making them qualitatively

different to those formed in civilian communities (Carron, Brawley and Widmeyer 1998 cited in Ahronson and Cameron, 2007; Manning, 1994). Lifton (1973) described the collective cohesion he observed in Vietnam veterans as "the intense cooperation, brotherhood and mutual love characteristic of and necessary to military combat" (p. 40), and others have described it as a *traumatic membrane* (Garfield and Leveroni, 2000). Cohesion within the military and other emergency service organisations may be achieved in both *preparation for* trauma (i.e. through training), and as a *consequence of* trauma, within the collective. The salient issue around cohesion occurring in a collective environment is that it cannot be created in isolation or in an individualistic context. Cohesion requires another or others and highlights the inter-relational and emotional aspect of military service. Cohesion has also been identified as psychologically protective from traumatic sequelae, which may explain why soldiers serving in highly cohesive units are generally more resilient (whilst serving) than those serving in units of lower cohesion (Wright et al., 2013).

In essence, collectivism and trauma may diminish the sense and experience of a personal self in-here and strengthen collective self out-there. The cohesion may be seen as the *self-in-the-other* and the *other-in-the-self*, creating the strong connection and enmeshment between self and other which is the foundation of military strength:

> When I was cold, *everyone* was cold. We were all hungry *together*. We were *all* scared s**tless. When we were out of water, we were *all* out of water.
>
> Vietnam veteran cited in Lifton (1973, p. 267)

Understanding the negative impact of trauma on the individual self and the positive impact it has on the collective may clarify why many members of the military look to it, or to each other, for identity and thereby psychological organisation. This strength within the military may however, prove to be an Achilles heel when a soldier moves from a military team environment to a rehabilitation or civilian environment, where they may feel disconnection, with a diminished individual self and collective self. The challenge for soldiers to maintain psychological organisation when transitioning from a collective culture underpinned by trauma, to an individuated civil culture may thus be more significant than has been reflected in military discourse to date.

1.2.3.1.2 Experience of serious wounds, injury, and illnesses

When serious wounding, injury or illness threatens a soldier's belonging to the group from which they gain much of their identity and direction, concepts of self may be disrupted. The link between injury, illness, and mental health issues are well documented, both contemporaneously and historically. It follows that, although fundamentally adaptive in

context, the collective self constructed during military service, may be experienced or perceived as psychologically unhealthy if articulated out of context, such as during transition to a relatively self-reliant rehabilitation or civilian society. Manning (1994), for example, summarised the findings of a 1946 examination of World War II (WWII) combat exhaustion thus:

> … the actual event which finally overwhelmed the psychiatric casualty's defences varied widely, but the common denominator … involved a sudden change in the soldier's relationship to his group. Somehow he had lost his place as a member of the team, whether it was he who changed, or the team.
>
> (p. 2)

More recently, Wainwright, Williams, and Turner (2005) noted that the body, career, and self are inextricably intertwined, specifically through examination of how the concept of self within professional ballet dancers was affected by serious injury. Though different in function and form, both soldiers and dancers undergo rigorous training amongst a select cohort that sees them forgo normal 'civilian' activities. For soldiers and dancers alike, physical abilities are inextricably linked to their ability to perform, and thereby fill a role within a highly cohesive, demanding and valued group. Thus dancers, like soldiers, submit their bodies and thereby their identity to a potential paradox. Performing the very roles which admit soldiers and dancers to the corp places them at high risk of injury and thereby potential expulsion from it. The study of these professional dancers highlighted how injury is strongly associated with a fractured identity and a decrease in social connectedness for these otherwise high performing and cohesive professionals. A fractured identity, especially as it results from changes in function and social connectedness, may have mental health implications, which may explain why traumatic injuries are associated with psychiatric disorder and further disability (e.g. Bryant et al., 2010; O'Donnell et al., 2009).

1.2.4 Medically-mediated transition and mental health

To reiterate the points above, soldiers are recruited during a critical period of identity development, wherein they submit some of their personal identity formation to collective identity formation. The military and other emergency service organisations necessarily operate in a trauma-mediated culture characterised by common meaning and common bonds, within a primary or familial social structure. The two hallmarks of what Erikson (1966, 1968) described as representing successful identity formation—differentiation and fidelity—are complicated by military service: differentiation is altered through a collective and cohesive culture, whilst fidelity, that is a commitment to occupation and industry, can only be maintained in the very specific context of the military. To be both a soldier and a civilian

therefore, may represent identity conflict or confusion, which in turn, may impact an individual's sense of self-directedness or agency (American Psychiatric Association, 2013). Collectively, a person's sense of identity and agency is often referred to as their sense of self. This dilemma of self was succinctly described by a Vietnam veteran on discharge thus: "I didn't know what to do [agency], I didn't know what I could become [identity]" (Lifton, 1973, p. 286). Although the identity of a veteran may be available instead of a serving soldier, what it *means* to be a veteran is not fully understood.

In contemporary military culture, leaving the team is associated with loneliness and feelings of alienation (Brewin et al., 2011; Demers, 2011); additionally, mental health professionals acknowledge that what is now understood as PTSD is symptomatic of shifts in identity (Garfield and Leveroni, 2000; Van der Kolk, McFarlane, and Weisaeth, 1996; Brewin et al., 2011). The link between identity change, post-traumatic stress, and negative health behaviours is supported by Brewin et al. (2011) who first reported a link between PTSD, changes to a negative view of the world, and suicidality. Experiences of trauma and resultant disruptions of identity may also be related to changes in personality constructs in the veteran population (Garfield and Leveroni, 2000). Dunn et al. (2004) reviewed several studies examining the comorbidity of depression, PTSD, and potential personality disorders in veteran cohorts and found prevalence ranged from 31%-79%. Signs and symptoms suggestive of avoidant, obsessive/compulsive, and borderline pathologies were most commonly reported (Bollinger et al., 2000; Faustman and White, 1989; and Dunn et. al., 2004; cited in Dunn et al., 2004).

So far, it has been identified that identity relates to agency, which is broadly understood as a person's sense of self—disruptions of which have been associated with conditions such as loneliness and feelings of alienation (Brewin et al., 2011; Demers, 2011), PTSD (Garfield and Leveroni, 2000; Van der Kolk, McFarlane, and Weisaeth, 1996; Brewin et al., 2011), suicidality (Brewin et al., 2011), and symptoms of personality disorder (Garfield and Leveroni, 2000; Boliinger et al., 2000, Faustman and White, cited in Dunn et al., 2004). However, a person's sense of self can also influence health and health behaviours more broadly (Marks et al., 2000). Given these links between self and feelings of loneliness and alienation, PTSD, suicidality and personality disorders, and given these are issues are associated with military personnel and veterans, self-constructs such as identity and agency may be critical to military medicine and veteran health discourse.

1.3 Theorising veteran experiences of rehabilitation and transition: the concept of self

As an academic discipline, military medicine has two interests. The first relates to preventative interventions that help maintain the health of military personnel, and the second relates to clinical interventions that help return the wounded, injured, and ill to duty (Craig, 2014). Although the care of those who sustain wounds, injury, or illnesses in service begins within the military, there is no current theoretical frame within it that accounts or attempts to integrate military medicine with the civil healthcare system, which may otherwise inform interventions and care for this critical population. While there are major active interfaces between services at the level of service providers and veteran clients, there is no effective overarching theoretical basis to facilitate clinical services, administrative services, or research priorities; nor is there a framework to critically analyse these. This lack of a theoretical frame is especially problematic in the Australian context because the closure of veteran hospitals in the 1980s resulted in a significant decline in psychiatrically-informed veteran care (A.C. McFarlane, personal conversation, November 2016). This conceptual void was noted earlier in this chapter by reference to Shields et al. (2016) who highlighted the lack of coordinated understanding of military to civilian transition and the subsequent confusion it creates. The void further presents as a problem when considering the mental health of military personnel during times of transition, especially for those under 25 years of age, and for those forced to leave the military on medical grounds (Centre for Suicide Prevention, 2014; Fear et al., 2009; Parliament of Australia, 2017; Australian Institute of Health and Welfare, 2017).

To help conceptualise military to civilian transition, especially in the instance of involuntary discharge as a result of serious wounds, injuries, or illnesses, the concept of self will be employed to frame experiences of participants in this study. As mentioned previously, the military requires its members, for the most part, to operate in a collective, cohesive, and relatively *self-less* way (Department of Defence, 2017; Ministry of Defence, 2017b; New Zealand Army, 2017; United States Army, 2017), despite being recruited from (and discharged to) industrialised and democratic societies marked by individualism, fragmentation, and *self-awareness* (Demers, 2011). Due to this distinction, the concept of *self* —the locus of identity and agency (American Psychiatric Association, 2013) may be a critical, if neglected, theoretical construct in the field of veteran health.

1.3.1 Self

Self is a concept which is often taken for granted (Kroger, 1996) by clinicians, academics, and professionals who, by virtue of their societal roles, are likely to possess a well-developed

personal sense of self. Although there are multiple understandings of self, with variation evident across academic disciplines, the idea that the self acts as an interface which connects a person to others and the world may be somewhat universal (McIntosh, 1995). Acknowledging the diversity of self-constructs throughout disciplines and time, the emerging guideline as to what constitutes self in terms of personality function (proposed by the American Psychiatric Association, 2013), is intentionally utilised in the current research. The American Psychiatric Association suggests that self is the sum of a person's individual identity and sense of self-directedness, expressed in the current research as agency:

> Self:
>
> 1. Identity: Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience.
>
> 2. Self-direction: Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behaviour; ability to self-reflect productively.
>
> American Psychiatric Association (2013)

The language of identity, which is central to self, has also varied between disciplines and over time, with terms such as "identity", "self", "ego", "I" and "me" being used somewhat interchangeably (Erikson 1968, cited in Kroger, 1996, p. x). Identity has also been described as a "lifelong evolutionary process of meaning-making, … an ongoing process of finding, losing, and creating new balances between that which is regarded as self and that which is taken to be other" (Kroger's articulation of Kegan's concept, cited in Kroger, 1996). Identity may also be understood as an "observing centre of awareness" (Erikson 1968, cited in Kroger, 1996, p. x) which is developed in the psychic maturational process, giving a person a sense of separateness and differentiation from others and the environment.

As stated in the excerpt above, to have a sense of self is to have a degree of both identity *and* self-directedness, the latter of which is a corollary of agency because "If individuals do not have a clear sense of identity they will not have a clear sense of their motives, goals, attitudes, values or set of social roles" (Ward and Styles, 2003, p. 351). In short, a person must know who they are in order to know what to do.

According to the American Psychiatric Association, self is also directly related to interpersonal function, which ideally involves empathy and intimacy, thus:

> Interpersonal:
>
> 1. Empathy: Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding the effects of one's own behaviour on others.

> 2. Intimacy: Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behaviour.
>
> American Psychiatric Association (2013)

Together, the constructs of self and interpersonal function constitute personality function (American Psychiatric Association, 2013) and are reflective of the industrialised, and democratic societies from where veterans are recruited and to where they must discharge. Although these definitions are relatively succinct, the American Psychiatric Association (2013) also encourage consideration of cultural influence around the concept of self in both clinical practice and research; as such, it offers a solid foundation for development of veteran health theory.

Self may also represent the sum of the system that accounts for the physical, psychological and social elements of self (Engel, 1977)—a concept most familiar to those in health-related fields, as the *biopsychosocial model*. The subjective experience of self, usually expressed as "I" (Gomez, 1997), connects the biopsychosocial parts of self deeply in the mind, before they are expressed, realised or considered as separate entities (Guntrip, 1961) and it is this whole self that relates to others. Within this thesis, the concept of self identified as most relevant to the data and analysis presented is situated within the psychodynamic object relations tradition, where it is ultimately utilised as means of understanding relationships. Both concepts are discussed below.

1.3.2 Biopsychosocial self

It is well recognised that a holistic approach that accounts for the physical, psychological, and social elements of self is necessary to maintain the health of those who serve in the military, and to restore them to duty after wounding, injury or illness. Indeed, this approach has been encouraged by military psychiatry, at least since the aftermath of World War I:

> [In 1922] Salmon [a military physician] suggested that all general practitioners should be educated in the principles of psychiatry to improve their skills in treating these patients [with early symptoms of mental illness]. In addition, he emphasized the importance of holistic or patient-centred healthcare over disease-centred and specialist health care.
>
> Pols and Oak (2007, p. 2193)

Affirming patient-centred healthcare, psychiatry came to develop what is now understood as the *biopsychosocial* model of health, an approach which accounts for the dynamic system that exists between these parts (Borrell-Carrió, Suchman, and Epstein, 2004; Engel, 1977), or the sum total of self. This dynamic approach came to challenge the dualistic or reductionist

biomedical model that dominated the 20th century (Borrell-Carrió, Suchman, and Epstein, 2004; Engel, 1977), and which is still called into question today (McFarlane, 2017).

The introduction of the biopsychosocial medical model was largely attributed to the psychiatrist George Engel in 1977, and in 1978, the framework was key to the declaration of the Alma-Ata, which spearheaded the primary healthcare priorities of the World Health Organisation at that time (World Health Organisation, 1978). The late 1970s (a period that also corresponded with the aftermath of the Vietnam war) was critical to the development of a person-centred, holistic approach to healthcare (World Health Organisation, 2008)—just as Salmon had proposed over half a century before (Pols and Oak, 2007). However, a comprehensive account of self, as it related to health, was earlier and similarly proposed by a leading psychoanalytic object relations theorist, Harry Guntrip, who asserted:

> We shall take up the position that every study of human beings, from any aspect whatsoever, should be kept well subordinated to the basic fact that, unlike all other organisms, it is man's potentiality to become what we mean by a 'person', and his true destiny (whether fulfilled or not) is to mature an individual personality in the medium of personal relationships. One may study man from the physiological, biological, psychological or again from medical, social or religious angles. But all these studies get out of focus unless controlled by the over-all understanding of what a human being is in his total nature … . That what is to be treated is not a disease entity but a patient who is a human person. [gendered language in the original]
>
> (1961, pp. 38-39)

This holistic approach may also be usefully understood as one that accounts for the whole of self, a concept bound with issues of body, mind, and society, and the relationship between these, as well as the impact they have on identity and agency. All these elements of self must be considered in healthcare and understanding health behaviours, including help-seeking and compliance, because health "is intertwined not only with the character of the disease but also with the patient's self-definition …, compliance or non-compliance is not only a means of managing symptoms but also of managing self-identity" (Marks et al., 2000, p. 301). Self, from a psychoanalytic or psychodynamic perspective, therefore provides a useful frame in which to broadly consider the individual, as he or she relates to others, during military service and after it. For this reason, an account of self, embedded in medically informed psychodynamic object relations theory, is employed in this research. Further details of this approach and the rationale for its use are now provided.

1.3.3 Self and object relations theory

The process of developing a self, that is, a sense of identity and agency, may be expressed utilising psychodynamic object relations theory. This conceptualisation has particular utility

because psychodynamic formulations, born of psychoanalysis, are increasingly used to frame broad humanistic phenomena that cannot be accounted for in more reductionist fields (Braun and Clarke, 2006).

Object relations theory may be best described as the study of relationship between self (subject) and other (object). The word *object* in this context first appeared in Freud's work, as he described people as the object of drives through which gratification was sought (Gabbard, 2010). In more contemporary times, however, object may be understood to simply reference an-o*ther,* such as a significant person, symbolic object, or ideal that is external to the self and subjectively important enough to hold meaning (Gomez, 1997). It is these objects, or others, that are identified with through *affect*, and eventually taken in as one's own (Gomez, 2017). Theorists such as Fairbairn and Winnicott conceptualised others as objects, linked by affect, to which proximity is sought (Gabbard, 2010). In this context, the term *objects of affect-tion,* is deliberately used to describe others, with the root word *affect* being of primary importance, denoting the emotional state linking self and others (Fairbairn, 1952; Gabbard, 2010; Guntrip, 1961).

In short, objects begin external to the self *out-there* but through a process of affective identity formation (Spitz, 1965 cited in Modell, 1968), what or who is out-there comes to situate *in-here* as internal representations of the self (Gabbard, 2010; Sherwood and Cohen, 1994; Fairbairn, 1952; Modell, 1968). A self/other *balance* may thus be understood to exist on a continuum. At one end of the continuum, the salience of identity may be situated out-there in the other, and at the alternative end it may be situated in-here, as one's own observing centre of awareness (Erikson 1968).

Although identity formation begins with *connection and sameness* with others (Kroger, 1996; Modell, 1968), a mature identity is underscored with *separateness and differentiation* from them (American Psychiatric Association, 2013). Developmental theorists have suggested the separation/individuation processes may involve continually "leaving an old self-other balance and creating a new one" based on each person's unique identifications and relationships with the world (Kroger, 1996, p. 194). Although relationship remodelling may occur throughout life (Erikson, 1968; Feeney, 2008) it is generally agreed this balance is at the foreground of development during the first three years of life and again during adolescence (Blos, 1967; Kroger, 1996; Mahler, 1974).

As mentioned above, a person must know who they are in order to know what to do. Changes in identity may therefore, change how a person acts, relates, and behaves in all contexts, and (with relevance to this study), especially as they move from a collectivist to an individualistic

culture. In addition, again with relevance to the context of this thesis, the military is almost invariably associated with trauma, which is also thought to damage the functional and organising capacities of self (Prior, 2004; Van der Kolk, 2014; Van der Kolk et al., 1996), further complicating medically-mediated transitions in this population.

Finally, the ability to attach meaning to relationships, the mechanisms of which are outlined above, sets humans apart from other species (Modell, 1968). Therefore, the meaning made from relationships has the potential to steer people, and thereby societies, toward their greatest potential (Guntrip, 1961).

1.4 Historical precedence linking the military to medicine and psychiatry

World War II (WWII) is marked as a significant period from which ground-breaking psychodynamic developmental theories emerged, many of which were based on psychodynamic object relations theory, and developed by many scholars who were physicians *and* veterans that served in World War I, World War II, or both. These included Donald Winnicott, John Bowlby, Ronald Fairbairn, Michael Balint, and Wilfred Bion (Campling, 2001; Gomez, 1997; Van der Kolk, 2014). In addition to their medical training and war service, many shared personal histories of early separation from their families, which attuned them to the importance of familial or primary group relationships. As such, many of the concepts embedded with object relations theory have relevance to the experiences of current participants.

Of particular note, the advancement of group-based therapeutic techniques developed by Wilfred Bion was based on the needs of neurotic veterans returning from WWII, and used a peer-led group approach to explore personal relationships as they existed between suffering veterans, and others (Bion and Rickman, 1943). This approach was reported to be a radical disjuncture with therapy at the time because up until WWII many psychological interventions that aimed to help neurotic veterans did not account for their social and emotional needs, but were rather bound with the intellectual imperatives of those who delivered them (Ferenczi in Bion and Rickman, 1943; Gomez, 2017).

To address this problem, Bion emphasized the need to recognise and resolve the neurotic tensions that arose in communal settings, rather than treating or suppressing them directly; and, in doing so, help veterans gain personal and interpersonal awareness which they could later draw upon in civil society (Bion and Rickman, 1943; Campling, 2001).

> Treatment … should throw into prominence the way in which neurotic behaviours add to the difficulties of the community, destroying happiness and efficiency. If communal distress were to become demonstrable as a neurotic by-

> product, then neurosis itself would be seen to be worthy of communal study and attack [problem solving]. And a step would be taken to overcome resistance in the society.
>
> Bion and Rickman (1943, p. 678)

As suggested in the above passage, one of the neurotic features of veterans observed by Bion and his colleagues was that of *resistance*, which may have presented in ways we now understand as self-avoidance (i.e., the unwillingness to examine oneself), ambivalence, or control (Hartman and Zimberoff, 2004). Resistance, however, was not a phenomenon unique to veterans of WWII. Robert J. Lifton (1973) and Erwin Parson (1985) noticed similar patterns in Vietnam veterans who participated in group therapy, decades after Bion developed his techniques. Lifton noted that the veterans he worked with tended to use war stories to avoid exploring personal feelings, and Parson noted a phenomenon of *post-traumatic accelerated cohesion* which similarly thwarted progress: the former by actively deflecting conversation and attention away from the self, and the latter by quickly losing the self in the other. Either way, these insights are critical because self-avoidance may continue to be manifest in difficulties in psychotherapy (Foa et al., 2009; Forbes et al., 2010) and underutilisation of healthcare services in the contemporary context (Currier et al., 2012; Hoge et al., 2004; Jakupcak et al., 2013; Pols and Oak, 2007; Tsan et al., 2012). Although problematic in a therapeutic context, self-avoidant behaviours may stem from the highly adaptive and appropriate mindset required for military operations as well as trauma (Van der Kolk, 2014; Van der Kolk et al., 1996).

1.5 The current context

Although many contemporary civilian therapeutic communities benefit from the group approach pioneered by Bion during WWII, these insights (and those they are founded on) are currently absent in veteran health discourse and treatment approaches in Australia. Instead, currently favoured psychotherapeutic interventions offered to veterans for affective disorders, substance abuse, and PTSD are based on cognitive behavioural therapy and its derivatives (Department of Veterans Affairs, 2012a, 2012b, 2012c). These approaches tend to be generalised and focussed on the correction of personal cognitions and behaviours, without fully accounting for the individual or the unique relationships (and the personal impact of them) forged in service. There is, moreover, much evidence to support the effectiveness of cognitive and behavioural approaches for civilians, but less so for veterans. A recent review of randomised clinical trials for military-related PTSD revealed that almost 70% of those undergoing treatment in cognitive processing therapy retained their diagnosis, even though a large majority of participants were also taking medication (Steenkamp et al., 2015).

It seems likely that, just as the concept of self may be different for military personnel and veterans, their concept of health might also be different. This is important because without an understanding of what it is that these individuals are seeking to re-gain, there may be a mismatch between the goals of clinicians and veterans, as has been suggested elsewhere (Messinger, 2010a; 2010b). Clearly, there is a need for further development of theoretical underpinnings of the impact of war on veteran health from a psychological perspective, to frame clinical approaches adopted by health professionals caring for contemporary veterans within military and civilian community settings.

In addition, despite the clinical advances gained during WWII and Vietnam, several writers have observed that the field of veteran health is yet to establish a solid and rigorous theoretical foundation to underpin clinical practice (Peterson et al., 2011; Pols and Oak, 2007). Others (e.g. Shields et al., 2016) have similarly described a conceptual void in the field of transition. Accordingly, leading contemporary experts in veteran mental health have recommended:

> … the development of improved treatments, creative integration of new approaches driven by sound theoretical principals is most welcome in the field … thus contributing to optimal public health across national boundaries.
>
> Foa et al. (2009, p. 3)

Given that military to civilian transition, and rehabilitation are both transitional phases faced by veterans, development of theory that encapsulates transition in a medical context may assist in resolving current health and clinical challenges for veterans and those who care for them. These include high levels of comorbid physical, psychological and social health conditions (including suicidality), as well as the tendency for military personnel and veterans to avoid healthcare services.

1.6 Gap in knowledge: impact of sense of self on veteran health behaviour

To summarise the above, a veteran's identity is affected by: collective military recruit training; experiences within the military, which may include trauma-mediated cohesion; wounding, injury, and illness; as well as military to civilian transition. Identity is related to agency (American Psychiatric Association, 2013; Lillevoll, Kroger, and Martinussen, 2013), and identity and agency are related to health behaviours (Marks et al., 2000). Despite this, there has been no research identified which seeks to understand how a soldier's sense of self or shifts in self may impact on health behaviour, either within the military, during transition, or beyond. Additionally, there remains a conceptual and theoretical void to help frame military rehabilitation and transition practices, identify gaps in knowledge, and thereby steer

research priorities (Shields et al., 2016). For these reasons, development of theory via exploration or dialogue around the implications of a collective and cohesive mindset on veteran health or health behaviour within both the military and civilian community, seems called-for.

Chapter 2. The current research

2.1 What does it address?

This research aims to examine how a soldier's identity is affected by serious wounding, illness or injury, and how this may impact on their health and health-related behaviour.

2.2 What are the research questions?

Primary questions

1. How do high-risk combat soldiers who are undergoing rehabilitation for serious wounds, injuries, and illnesses perceive themselves during rehabilitation and transition?
2. What are the implications of these perceptions for health and health behaviours?

Secondary questions

1. How are the identities of high-risk/highly cohesive combat soldiers affected by a downgrade in their Medical Employment Categorisation?
    a. How do they experience themselves?
    b. How do they experience others?
    c. How do they perceive how others experience them?
2. What is the nature of how 'health' is understood by high-risk/highly cohesive soldiers?
3. How do high-risk/highly cohesive combat soldiers relate to and utilise health care services during rehabilitation, and more broadly?
4. What meanings do high-risk/highly cohesive combat soldiers attach to their wounding, injury or illness?
5. How are attitudes and health behaviours affected by a downgrade in Medical Employment Categorisation of risk/highly cohesive soldiers?
6. What do they perceive as helpful and not helpful to the rehabilitation process?

2.3 Analytical approach and method

A qualitative contextual thematic approach, imbedded in the dynamic between non-relative social constructivism and critical realism, guided methodology in terms of developing the project, sampling the population, choosing questions, interview style, and transcription—all of which helped obtain and prepare data for analysis (Willig, 2012). The justification for, and the process of the research are detailed below.

A qualitative contextual thematic approach rooted in the dynamic between non-relative social constructivism and critical realism was chosen to study the relationships between military personnel, and their health and health behaviours during rehabilitation and transition. This approach was chosen because it acknowledges and allows for exploration of epistemological subjectivism (the personal accounts and meaning participants ascribe to themselves, others and their experiences) within the very real and often necessarily rigid social constructs of the military—a situation that lends itself to ontological realism.

Much research has described patterns of veteran health and health behaviours in terms of health outcomes (i.e. symptoms, morbidity, and diagnoses), attitudes, beliefs and behaviours, in positivist and quantifiable terms (Shields et al., 2016). The approach taken within the majority of research to date is reductionist and predominantly seeks to identify *causal* relationships between variables such as age, gender, cognitive styles intelligence, personality types and symptoms—all of which are categorised and considered separately (Willig, 1999). Whilst this approach has provided insight to guide assessment and treatment, it has limitations. The most significant limitation is that categories are completely isolated before they are studied, which ignores (and thereby excludes) the complex whole from potential explanation and theory. These experiences and meanings can only be achieved through examining the ways in which people talk about subjects (themselves), objects (other people and things), and the relationship between the two, over time (Willig, 1999), thus reflecting the individual as a highly contextual phenomenon:

> Parts can be parts only when there is a whole for them to be a part of. It follows that the properties of parts have no prior alienated existence but are acquired by being part of a particular whole. Thus, what appears to be the ‘same’ unit may display very different characteristics in different contexts. Similarly, a whole can become a part of a bigger whole … what was once a part of a bigger can function as a smaller whole … subject and object as well as cause and effect can take each other’s place in a system.
>
> Willig (1999, p. 41)

Within the social sciences, complex subjective and culturally specific experiences or meaning can be accounted for by adopting a social constructivist approach. Social constructivism is a framework in which language and discourse are understood to represent the personal and social reality of participants, enabling researchers to reflect on how the phenomena of interest are constructed, and the consequences of these constructions for participants (Willig, 2012). Social constructivism is associated with ontological relativism in that it serves to challenge realist and positivist aims of objectivity, truth, and control, as well as established social order (Fletcher, 1996). Due to this perspective, social constructivism has been described as both

empowering and liberating to those negatively impacted by such constructs (e.g. gender limitations or diagnostic categorisations) (Willig, 1999). However, just as positivism has limitations, so too does social constructivism and this is especially the case when it is considered in a military context wherein objectivity, order, and control are critical for mission success.

The main critique of social constructivism is that it works to critique and deconstruct dominant paradigms, and the ways in which objects (people or things) are categorised, but it little accounts for the often-enduring material, social, or economic structures that uphold them, thus creating a potential conceptual void (Willig, 1999). In other words, social constructivism is useful to described what may be problematic with certain constructs, but less accounts for *why* they exist (for example, the military categorises its people to ensure they are fit to undertake a role), nor does it fully lend itself to proposing how things could be improved (Willig, 1999).

For the reasons outlined above, it could be construed that positivist approaches to knowledge (related to ontological realism) and social constructive approaches (related to ontological relativism) may be mutually exclusive methods as they relate to research design (Braun and Clarke, 2006). However, thematic analysis can be employed to contextualise data, taking a systems or dialectical approach, that oscillates between epistemological *non-relativist* social constructivism and ontological *critical* realism (Willig, 1999). The utility of this has been described thus:

> [A] contexualist method … [sits] between the two poles of essentialism and constructionism, and [is] characterised by theories, such as critical realism (e.g., Willig, 1999), which acknowledge the ways individuals make meaning of their experience, and in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'.
>
> Braun and Clarke (2006, p. 81)

A qualitative thematic contextualist approach was considered appropriate to this research because a) militaries are multifaceted organisations compiled of people that exist in various states and contexts (including during transitions in and out of the military), and b) because mission success in highly dangerous and unstable environments demands a high degree of control and social order. In addition, because there is currently little theory informing health-related transition from the military, a thematic contextualist approach (especially when embedded with a critical realist position) facilitates the creation of alternative constructs (to those dismantled), or potential solutions (Willig, 1999). This research thus holds the potential

to help build theoretical constructs (Carter et al., 2009) based on the experiences of participants, whilst accounting for the social and occupational demands of the military.

2.4 Semi-structured, in-depth interviews

As with all research, there are a number of alternatives to each stage of research design and analysis and decisions must be made as to which of these best supports the research aim (Braun and Clarke, 2006). After considering that one of the trade-offs of any research is that of breadth for depth (Patton, 2002), semi-structured, *in-depth* interviews were chosen as a means for data collection. The social constructivist element of the contextualised approach adopted for this study enabled the researcher to gain a high degree of depth and detail, thus opening the possibility for new insights in the context of the studied population. According to Russell Bernard (1988), qualitative interviews may be understood to exist on a spectrum, with a highly controlled or structured approach at one end, and an informal and little controlled, unstructured approach at the other. Bernard (1988) states that the former are designed to elicit speech in relation to near identical questions, but neither allows the researcher/interviewer scope to follow intuition or dialogue of interest, nor facilitates elicitation of what might be important to the participant. In contrast, informal or unstructured interviews place little or no emphasis on controlling what participants talk about. Between these two extremes sits the semi-structured interview that has some structure and some freedom. In this middle space, a guide is used to prompt the interviewer toward what needs to be discussed, but simultaneously allows both the interviewer and participant to focus on speech that is of importance or interest as it arises (Bernard, 1988).

In-depth interviews are also widely accepted as compatible with research investigating health and illness, particularly in populations that are few in number, hard to access, vulnerable, or marginalised (Liamputtong, 2013). These characteristics, whilst not always associated with a military population, may be considered factors associated with military rehabilitation because marginalisation within a unit context may precede potential marginalisation within a broader social context, upon medical discharge.

A semi-structured in-depth interview style was chosen to guide questions in two series of interviews with participants. The first series of interviews, conducted between March and April of 2014, were designed to elicit discussion regarding the biopsychosocial elements of participants' health and well-being over time, with a focus on their choices and their current situation (see appendix 1). The second series of interviews, conducted between September and December of the same year, also employed a semi-structured technique. This allowed the researcher to gain further insight into themes of interest identified in the first series of

interviews, and provide an opportunity for member validation (Bygstad and Munkvold, 2007) (see appendix 2).

To enable accurate re-presentation of participants' experiences, interviews evolved to employ a timeline elicitation technique (Sheridan, Chamberlain, and Dupuis, 2011) where the researcher and participant worked with colour-coding to assist in developing their perspectives of health and motivation. Participants were asked to use blue to mark the timeline in relation to their physical health, with green and red used to represent social and psychological aspects of themselves, respectively. Participants were encouraged to mark the timeline as many times as required to best represent themselves both in health and during change, upon which further prompt questions were asked, e.g. "what does that mean to you?", "can you tell me more about that?" and "what was going on around then?" Key thoughts or phrases expressed by participants were also placed onto the timeline to check and confirm mutual understanding between participant and researcher.

This technique proved a helpful tool, enabling participants to make sense of, and re-present, their complex experiences whilst providing a degree of structure for the interview. Figure 1 represents a typical partially completed timeline, oriented around five periods: civilian, conventional soldier, operator, rehabilitation, and the future. A sample of a completed timeline is in appendix 3.

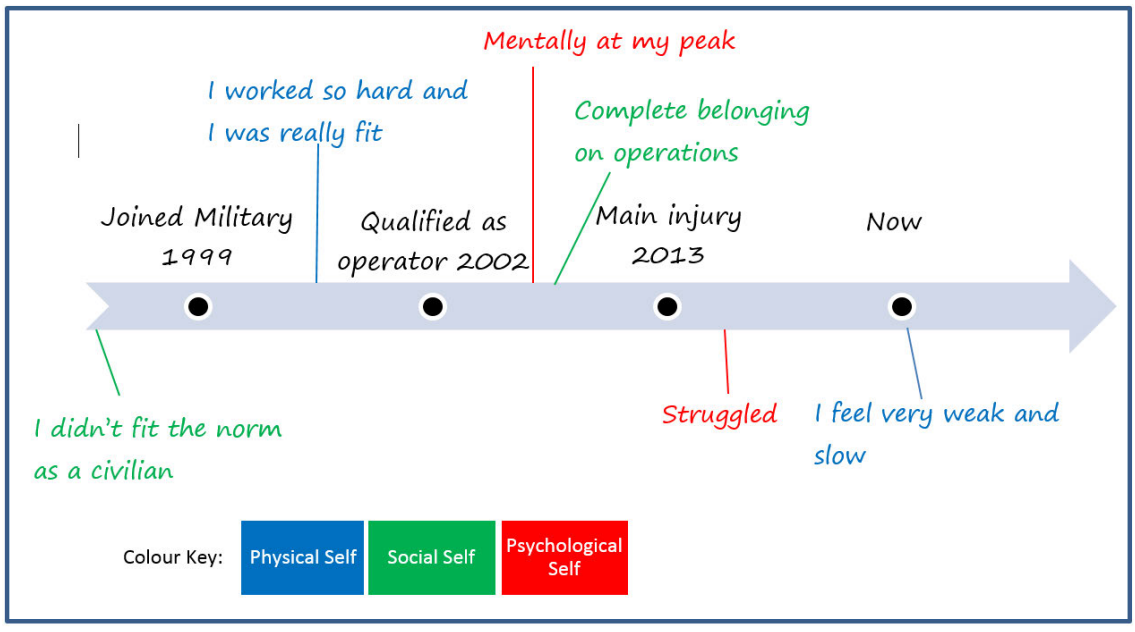


Figure 1. Depiction of a typical timeline used to elicit and represent participants' perception of self over time

It is important to note, the qualitative contextual approach to this research (grounded in the dynamics between non-relative social constructivism and critical realism) sought to elicit data

relating to subjective experiences of participants during and regarding rehabilitation and transition, rather than the experiences of their condition per se. This nuance is significant because the aim of the research was to understand participants as a whole, as they interfaced with their world (DiCicco-Bloom and Crabtree, 2006) rather than focussing on and thereby partially reducing them to their specific wounds, injury, and illnesses. To achieve and maintain this focus, questions such as "can you tell me about your wound/injury/illness?" "what happened?" "how did it happen?" "where did it happen?" were specifically avoided. The question of "when did it happen?" was, however, folded into the questions to denote a juncture in their lives. Nonetheless, although questions of "*what, how, and where?"* were not specifically asked, many participants chose to talk about these topics as the interviews unfolded, but only in the context of the meaning they attached to it in the context of their whole journey, and as they considered themselves and others, more broadly. The approach worked well and some participants (outside the formal interviews) mentioned it was a welcome relief to the focus usually directed toward their condition elsewhere. It is the researcher's perception that drawing attention away from "what happened" helped to build trust and rapport with participants.

Most interviews were conducted in a private office within a community facility, located on the military base, but outside participants' unit. Five participants preferred to be interviewed in or near their homes. During the second series of interviews, two participants were interviewed via telephone as one was training and the other on operational deployment. Each interview lasted approximately two hours and collectively yielded approximately 50 hours of primary data.

2.4.1 Ethical issues

Prior to data collection, this study was approved by the Australian Defence and University of Adelaide Human Research Ethics Committees (approval numbers 738-13 and H-2013-98 respectively). The interviewer was conscious that participants were recruited from a vulnerable population (Liamputtong, 2013). Some participants, such as those experiencing psychological distress or illness, or who were on medications (that may impact decision making), were considered further vulnerable. In addition to normative ethical considerations (e.g. informed consent, confidentiality) steps were taken to ensure the well-being of all participants during and after interviews, which included confirmation of their willingness to voluntarily participate and their self-perceived capacity to do so.

Before participation in the research, all participants received an invitation to participate (see appendix 4). The invitations detailed the background of the research, potential beneficiaries,

what would be asked of participants, assurances around confidentiality, as well as unit and military endorsement. In addition, the background of the researcher was included and information of what to do if they wished to participate. The invitations were placed in individual envelopes along with a pre-paid, self-addressed envelope (to enable participants to contact the researcher with complete anonymity, if desired), which were then left in a discreet location within the researched unit.

Each participant was provided with an Australian Defence and Adelaide University Ethics Committee guideline (see appendices 5 and 6) that outlined how (and to whom) complaints relating to the research may be addressed. In addition, the Australian Defence guidelines reiterated the voluntary nature of participation, and the meaning of informed consent. A time lapse of at least 24 hours between providing ethical guidelines and commencement of the first interview was provided to ensure participants had adequate opportunity to consider their rights and options as volunteer participants.

Immediately prior to each interview, the researcher/interviewer used a checklist to ensure that adequate support services were identified and in place (see appendix 7) in the event that participants became distressed during the interviews. The researcher also obtained written informed consent from the participant (see appendix 8), which reiterated the participants' freedom to withdraw at any stage, without professional or personal consequence.

All participants agreed to the research terms, consented and participated accordingly. Although some became emotional during the interviews, none became distressed nor did they accept offers of further support. Indeed, at the close of the interview (once recording had ceased), many participants reflected that they experienced their emotions as cathartic and positive, rather than distressing. Nonetheless, emotional moments were managed through the provision of silence (Eliott, 2006), and the offer to pause the interview, thus providing the participant with personal space, at which time refreshments were offered. Under those circumstances, consent was always renegotiated prior to recommencement of the interview. Altogether, no participants complained or withdrew from the research.

The researched population existed within a tightly bound group, therefore particular attention was given to concealing the identity of participants at the transcription and reporting stages. This included changing identifying details such as specific locations, dates and the nature of wounds, injury, and illnesses and the decision to forego the use of pseudonyms, because of the potential for patterns of speech or behaviours evident across a number of quotes to be recognised and linked to participants.

Finally, because both the researcher and participants were military personnel, careful considerations were given regarding any real or perceived power imbalances. These included issues of recruitment (especially as they applied to potential coercion), managed in part by explicitly outlining the relational expectations between the investigator and participant, after the research. To that end, because the researcher was not at that time, nor ever would be in the participants' direct chain of command, the unit agreed that the military hierarchical relationship would not be expected or enforced between them. To demonstrate this negation of military rank in this context, all interviews were conducted outside the bounds of the unit and the interviewer always wore civilian attire during them.

2.4.2 Researcher position

There is some debate as to whether qualitative researchers should (or should not) be a member or the population they study—that is, if they should be insiders or outsiders (Dwyer and Buckle, 2009). This debate has often centred around the paradoxical position of a qualitative researcher, succinctly expressed thus:

> The qualitative researcher's perspective is perhaps a paradoxical one: it is to be acutely tuned-in to the experiences and meaning systems of others—to indwell—and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand.
>
> Maykut and Morehouse, 1994 in Dwyer and Buckle (2009, p. 55)

In a postmodern context, the position of the researcher (i.e. as occupying a class, gender, ethnicity, or occupational role) is often considered as a critical element of qualitative research because considering it draws conscious attention to power relations that may impact interpretation (Angrosino, 2005 in Dwyer and Buckle, 2009). Insider researchers, who belong (to a large degree) to the population they are studying, may be considered to have more credibility and greater access to the population they seek to study (Dwyer and Buckle, 2009) and because of this, are usually able to obtain a greater depth and breadth of data relative to outsiders (Kanuha, 2000). With this privilege comes issues of potential emotional strain (Dwyer and Buckle, 2009), along with questions of reflexivity, objectivity, and authenticity, as the researcher may be (or become) too familiar or similar to the researched population, such that they fail to question the taken-for-granted (Kanuha, 2000). In contrast, outsider researchers have been criticised for their reduced capacity to appreciate and thereby possibly synthesise complex, sensitive, and emotional experiences (Dwyer and Buckle, 2009) inherent to that context of the studied population, whilst carrying (and thereby being influenced by) personal perspective (Dwyer and Buckle, 2009).

In this study, the interviewer held a dual insider-outsider position (Dwyer and Buckle, 2009). As a general military officer, the researcher could be deemed to be an insider, because she held a degree of cultural insight and was conversant in military language—attributes that enabled her to be taken seriously by and thus connect with participants. Nonetheless, being both female with a healthcare background, and in a researcher role, she was also an *outsider*. In the researched population, this dual position was critical to the conduct of the research. Specifically, occupying an insider position enabled a degree of trust and authenticity, which was central to participant recruitment, whilst the outsider position provided a useful boundary or distance which enabled observation of phenomena without being enmeshed in it (Dwyer and Buckle p. 59, paraphrase of Fay, 1996).

The dual position of insider and outsider in this research demanded that the investigator practice continuous self-reflection throughout the study. Central to this reflection was the acknowledgement that it is impossible for those with a degree of insider positioning to be completely objective and distant from their research, despite being charged with the responsibility of accurately analysing, shaping and documenting participants' experiences (Liamputtong, 2013). Such reflection served to acknowledge and account for personal bias, history and perspectives, at all stages of research design and interpretation, yet allow for the human processes of interpretation (Carpenter and Suto 2008, in Liamputtong, 2013)—thus minimising the projection of personal needs onto participants (Watson 1999 in Dwyer and Buckle, 2009). This reflection mostly occurred alone and noted in the NVivo qualitative research tool (QSR International Pty Ltd, 2012). When further perspective was deemed beneficial to understanding and accounting for potential bias in the process of reaching a position, the interviewer reflected with real outsiders and real insiders who were personally known to her. The outsiders included her supervisors, other academics, and clinicians. The insiders included those who were (or had been) in similar military units, and in similar situations to those in the studied population. In addition, the themes identified by the researcher throughout analysis, along with supporting data, were reviewed by the principal supervisor, with any differences in interpretation further resolved through discussion.

2.4.3 Sampling the population

Qualitative sampling methods differ considerably to those usually employed in projects that aim to quantify results. In the latter, large samples are most often sought because they address issues such as frequency (e.g. how often or how much something occurs) and use results to make generalisations or predictions (Hesse-Biber and Leavy in Liamputtong, 2013). In contrast, qualitative research aims to elucidate depth and the meaning/s that participants attach

to their experiences, which involves obtaining a lot of information from a small number of people (Liamputtong, 2013).

This study used a purposeful, non-probabilistic sampling technique wherein participants were carefully recruited for the rich information they could potentially provide in relation to the research questions (Liamputtong 2013), which related to the experience of rehabilitation after serious wounds, injury, and illnesses, in a military context. To enable the collection of rich data, participation criteria was strictly limited to those who were fully qualified high-risk combat soldiers (and employed as such); sustained physical and/or psychological wounding, injury or illness in training or on operations; were medically *down-graded* as a result of their condition (that is they were not able to perform in the role for which they were employed); and were undergoing rehabilitation for the condition that led to their medical down-grade. The "down-graded" criterion was considered central because, from a critical realist perspective, it provided an objective marker of functional severity and thereby occupational disruption (i.e. it precluded individuals from performing in their role and working with their team).

Following receipt of ethical approval from the Australian Defence and Adelaide University Human Research Ethics Committees, the process of recruitment began with enlisting the unit medical and psychological officers, acting as gatekeepers, to introduce potential participants to the study (Liamputtong, 2013). This involved briefing the gatekeepers about participation criteria and requesting that they invite potential participants to the study, when they presented for clinical reasons, providing them with an invitation (outlined in section 2.41 and appendix 4). This approach, however, did not yield any potential participants, which is, in itself, illustrative of the issues of trust that were revealed as central in this research (see Chapter 4).

Following the unsuccessful attempts to recruit through the unit-based healthcare professionals, a senior high-risk combat soldier initiated a snowball method (Liamputtong, 2013) amongst the *brotherhood* (a colloquial term used by the soldiers to describe their relationship with their peers). Methodologically, this proved essential because of participants' tight-knit relationships based on trust, coupled with their reluctance to engage with health professionals. This amendment was approved by the relevant ethics committees, and enabled successful recruitment, with the information packs made available at a discreet location within the unit, for those who expressed interest.

Recruitment in this way continued to data saturation, that is, when no new themes related to the research aim were identified in subsequent interviews (Fusch and Lawrence, 2015). This occurred at 13 participants, which is consistent with assertions by others that codes and themes are usually established with approximately 92% accuracy, by the twelfth interview

(Guest, Bunce, and Johnson, 2006). This was particularly the case in the current research because the population was relatively homogenous and the interviewer held a degree of cultural competence that enabled her to readily communicate and relate to participants (Liamputtong, 2013) (see section 2.4.2 for more on this).

All participants were high-risk combat soldiers undergoing rehabilitation for physical wounds from operations (n=8), physical injuries (n=3), and psychological injury and illness (n=2). All were male and ranged in age from 32-39. At the time of writing, direct high-risk combat roles were open to females, but none had yet qualified.

2.4.4 Recording and transcription

All data were digitally audio-recorded on a dedicated audio-recording device and transcribed. There are various standards and degrees of detail associated with transcription, all of which have "interpretive implications" that relate to intended analysis and the researcher's theoretical position (Willig, 2012, p. 76). One way of considering transcripts in relation to different theoretical positions and research aims is to contextualise them in a similar way to interviews: that is, they exist on a spectrum. At one end of the spectrum, they are considered naturalised and at the other end they can be de-naturalised (Willig, 2012). Naturalised transcripts tend to capture fine details and linguistic subtleties of the interaction between the researcher and participant such as hesitations, false starts, pauses, stutters, volume, and timing. This approach ensures the final text is very close to the original utterance (Willig, 2012). In contrast, de-naturalised transcripts are usually grammatically corrected and tidied prior to analysis, which enables them to be read with greater ease with focus on meaning (such as discourse and language patterns), rather than the fine features of speech (Willig, 2012). As the transcripts in this study were created to identify the meanings participants attached to their situations, and the ways in which these related to health behaviours, a mostly de-naturalised approach was employed, with speech elements such as "um" "err" and "ah", along with pauses, interruptions and stutters, omitted (Willig, 2012).

Transcription was achieved by listening to the data and typing it directly into a word processing program, aided at times, by the use of voice-to-text software (Dragon Naturally Speaking), through which speech of the participants would be relayed in the researcher's own voice, to the software. Once transcribed, the data were thoroughly checked for accuracy and corrected where necessary, through re-listening to interviews in their entirety, while simultaneously reading the text (DiCicco-Bloom and Crabtree, 2006). Transcription usually occurred within 24 hours of each interview because immediacy has been reported to increase accuracy (Gillham, 2000), which was further achieved by providing each participant with a

copy of their interview soon after it, with the invitation to correct mis-represented speech. Apart from some detail that was intentionally changed to protect privacy (such as locations, names, dates, and specific health details), there were no reports of transcription inaccuracy or mis-representation. The final text was then entered into NVivo (QSR International Pty Ltd, 2012) to facilitate analysis.

Due to the small and intimate community in which participants worked, pseudonyms and participant identifiers were considered a risk to participants' identities and were subsequently not used in reporting. A fair and balanced use of participants' speech (ensuring that all participants' experiences are included in the analysis) was established when selecting quotes to illustrate themes under discussion. Quotes are numbered by chapter and consecutively within these (e.g. the first quote in Chapter 3 is number 3.1).

Some speech quoted in this thesis is condensed by way of omitting words deemed superfluous to the meaning conveyed. When this occurs ellipses are used in lieu of the omitted text.

Further, some quotes represent dialogue between the interviewer and participant. In this case, the speaker is identified. Although effort was made to ensure interview recordings were clear and audible, sometimes background noises (such as children and traffic) rendered speech undecipherable at the transcription stage. Undecipherable speech is identified as such within square brackets: i.e. [undecipherable].

Where meaning cannot be assumed to be accessible to the reader (perhaps through the use of terms familiar to those within the cohort and/or those with military training, but not others), square brackets are also used to provide brief explanation as to what the participant referred. Finally, expletives were retained in the text to ensure the *intensity* of meaning is conveyed, thus revealing the often emotional experiences of combat, rehabilitation, and transition. It is acknowledged, nonetheless that some may find such language offensive. To address the need to convey both meaning and intensity, whilst being mindful of readers' comfort, asterisks substitute key consonants and vowels in words that may risk offence.

2.4.5 Details of analytical process

2.4.5.1 Creation of datasets

The data corpus obtained and transcribed for this research project contained all the data (Braun and Clarke, 2006). The next stage of analysis involved manipulating the data corpus to create smaller datasets that related to specific analyses (Braun and Clarke, 2006) from which themes were identified.

Datasets can be created by either identifying patterns using inductive analysis which represents a data-driven bottom-up approach, or by using a more deductive approach wherein the data sought is driven by a researcher's analytic interests and questions (Braun and Clarke, 2006). Each of these analytic approaches has benefits and limitations. The former is not guided by theoretical interest, therefore it can provide a rich account of the whole data corpus, but may not help answer the research question. Conversely, the analyst's interests drive a deductive approach wherein the data corpus is approached with the explicit aim of looking for answers to the research question (Braun and Clarke, 2006). As this study was linked to a particular social problem (represented by the research question) for which a theoretical framework is available (i.e. sense of Self), datasets were created through deductive means.

To achieve this end, data were coded. Codes represent basic segments of data such as observations, paragraphs or sentences that are named, to represent and categorise their content (Strauss and Corbin, 1998; Holloway and Wheeler, 2010; in Liamputtong, 2013). These codes were then organised into meaningful groups, which were combined and sorted into possible themes (Braun and Clarke, 2006).

There are various methods of establishing codes and their names, for example, traditionally (particularly in grounded theory approaches) codes are established around actions and events (Liamputtong, 2013). Some suggest researchers simply ask themselves "what is this thing (or things) I have before me?" (Minichiello et. al. 2008, p. 286, in Liamputtong, 2013) and others suggest possible questions include "… Who? ... How? …When? How long? Where?... How much? How strong? …Why? … What for? … By which?" (Flick, 2006, in Liamputtong, 2013, p. 243). In addition to these approaches, contemporary qualitative analysis (such as Charmaz and Henwood in Liamputtong, 2013) have advocated for the coding of subjective *experiences* (i.e. the individual experience of who, how, and when etc.). In this study, participants' subjective experiences of encounters (such as others or events), personal behaviours, and actions were coded. Codes were created by using a sentence completion technique which enabled the researcher to capture and interpret the subjective perspective of the participant in relation to each segment of data (that being any expression of experience, including themselves and others).

At the most basic level, the researcher read each segment, and asked herself to complete a sentence that related to a research interest, each of which formed the basis (or part basis) for the analytical component of this thesis. To code the way participants experienced themselves in health, the researcher completed the following statement as it related to her interpretation of the participants' experience:

> Here, the participant experienced themselves as *healthy* when [insert code] (i.e. fit)

Transversely,

> The participant experienced themselves as *unhealthy* when [insert code] (i.e. taking medications).

The sentence completion technique was used for two reasons. First, social constructivism seeks to understand the subjective experience of participants. By completing sentences in this way, the researcher was able to contextualise segments of data from the participants' standpoint and consider the meaning attached to them, then creating a code or multiple codes. Where possible, code-names were created based on the speech of participants, or through the theoretical lens of self. Figure 2 illustrates how a data extract (taken from Chapter 4) and the codes generated in relation to how participants experienced health:

Data extract	**Codes**
[Health is] being able to do anything you want really … fit, strong. No injuries. You don't live without injuries, so I suppose it would be being able to cope with injuries more so.	Personal agency Fit Strong Coping with injury

Figure 2. Example of how codes were generated from the data

As illustrated in Figure 2, this means of coding enabled creation of datasets as they related to experiences of good and poor health, detailed below, which were viewed independently and in relation to each other (in this case, specifically by contrast), to identify themes (see Figure 3).

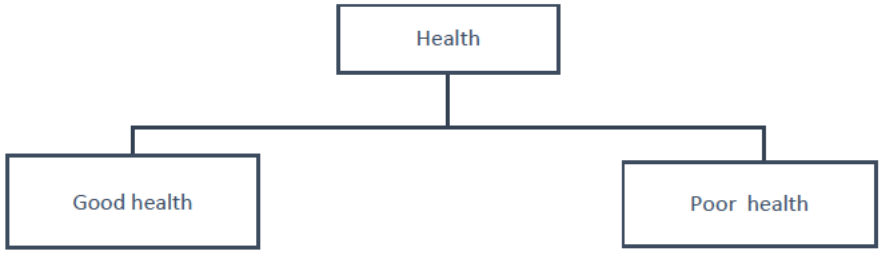


Figure 3. Example of how codes generated in relation to health may be considered independently or in relation to one another

Through the process of reading and reviewing transcripts, the researcher noted the importance of *values*, being as a psychosocial construct that represents what is considered desirable or

good, in the self and others (Bednarek-Gilland, 2015). Accordingly, speech connoting or referring to values were similarly coded by completing the following sentences:

> In this instance, the participant drew on the value of [insert value] (i.e. compassion)

or

> The participant described another individual in a similar situation as drawing on the value of [insert value] (i.e. tenacity)

As values relate to both the self and others, the codes generated in this way were, again able to be considered independently, or in conjunction with each other. In this way a second dataset was created in relation to values (Figure 4) thus enabling patterns to be noted and themed.

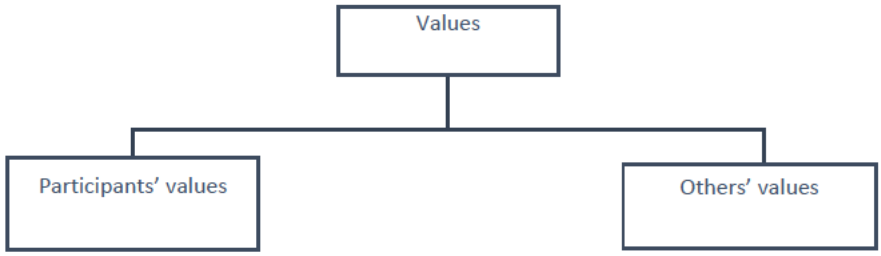


Figure 4. Example of how codes were generated in relation to values and how they may be considered independently or in relation to one another

A slightly more complex means of coding was used to create the dataset that documented the way participants experienced themselves over time. This involved the same sentence completion technique as detailed above, i.e.

> The participant experienced themselves as [insert code] (i.e. angry).

However, this dataset also included the dimension of time, as depicted in Figure 5 below. This enabled other themes identified, to be cross-referenced with time, allowing consideration of the experience of self, using a temporal perspective.

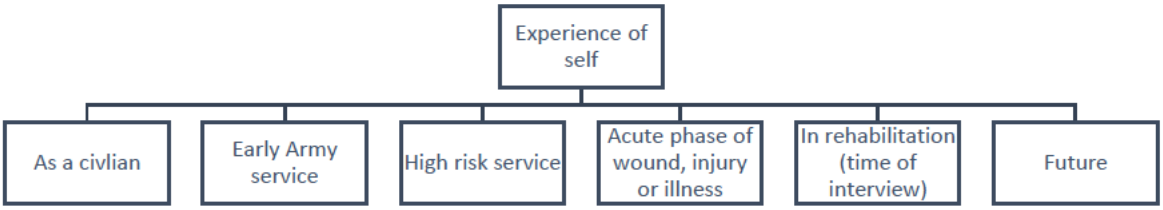


Figure 5. Example of how codes as they related to self over time, were considered

This coding also enabled identification of the ways in which participants perceived others as experiencing them. In this case, the sentence to be completed was:

> The participant perceived [the other/s] experienced him as [insert code for perceived experience].

As an example, sentences completed using the above technique may have read:

> The participant perceived his *family* experienced him as *angry*.

Codes were then created for each time period, as per the above. Figure 6 provides some examples of the developed coding:

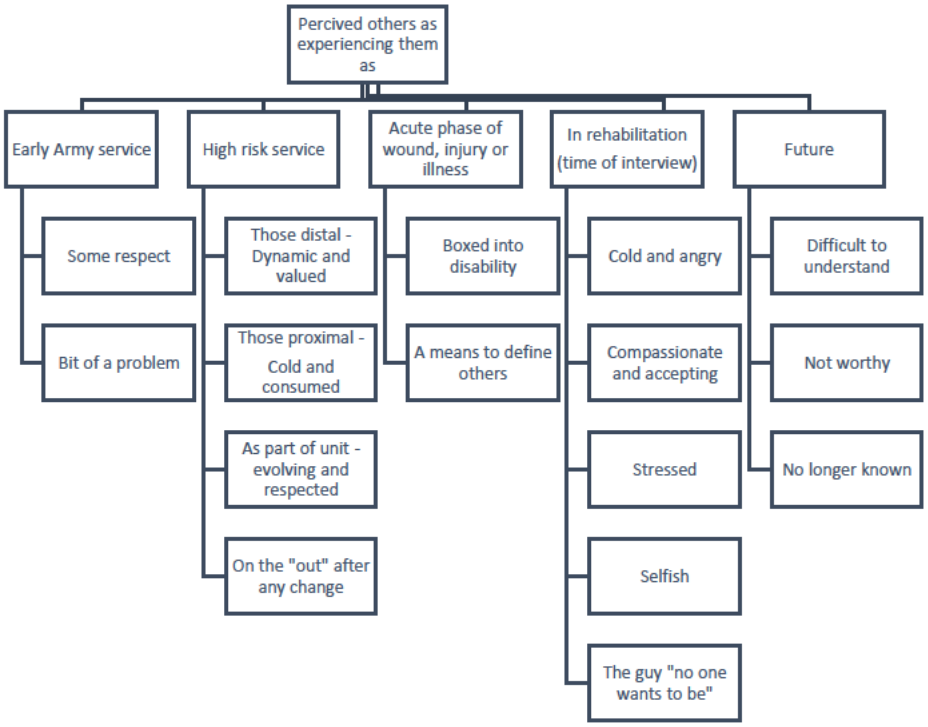


Figure 6. Coding scheme capturing how participants perceived others as having experienced them, over time

Again, codes that related to experiences of self, and those related to participants' perceptions of the way/s that others experienced them, could be then considered independently or in relation to one another. When codes were used in relation to one another, an overall sense of identity that incorporated self and others (or tensions that existed between these), could be recognised.

The final dataset was created by coding for the ways that participants experienced others, over time. This need for this dataset arose because during interviews, transcription, and reading, the researcher identified that these perceptions seemed to influence the motivations and behaviours of participants in all domains. In particular, who participants moved towards and who they moved away from (and why) seemed central to the ways in which they engaged with healthcare providers—an issue previously described as critical in the military and veteran communities (Currier et al., 2012).

Accordingly, to create this dataset, the sentence to be completed was:

The participant experienced [the other] as [insert code for experience]

The creation of these codes resulted in a complex dataset that accounted for the experience of specific others that participants talked about, over time. Codes for the 'others' were obtained inductively, in that the researcher's attention to these was not established a priori, but arose as they presented in participants' speech. A deductive approach was then applied to ascertain participants' experiences in relation to each group. Examples of those participants talked about, during specific periods, is depicted thus:

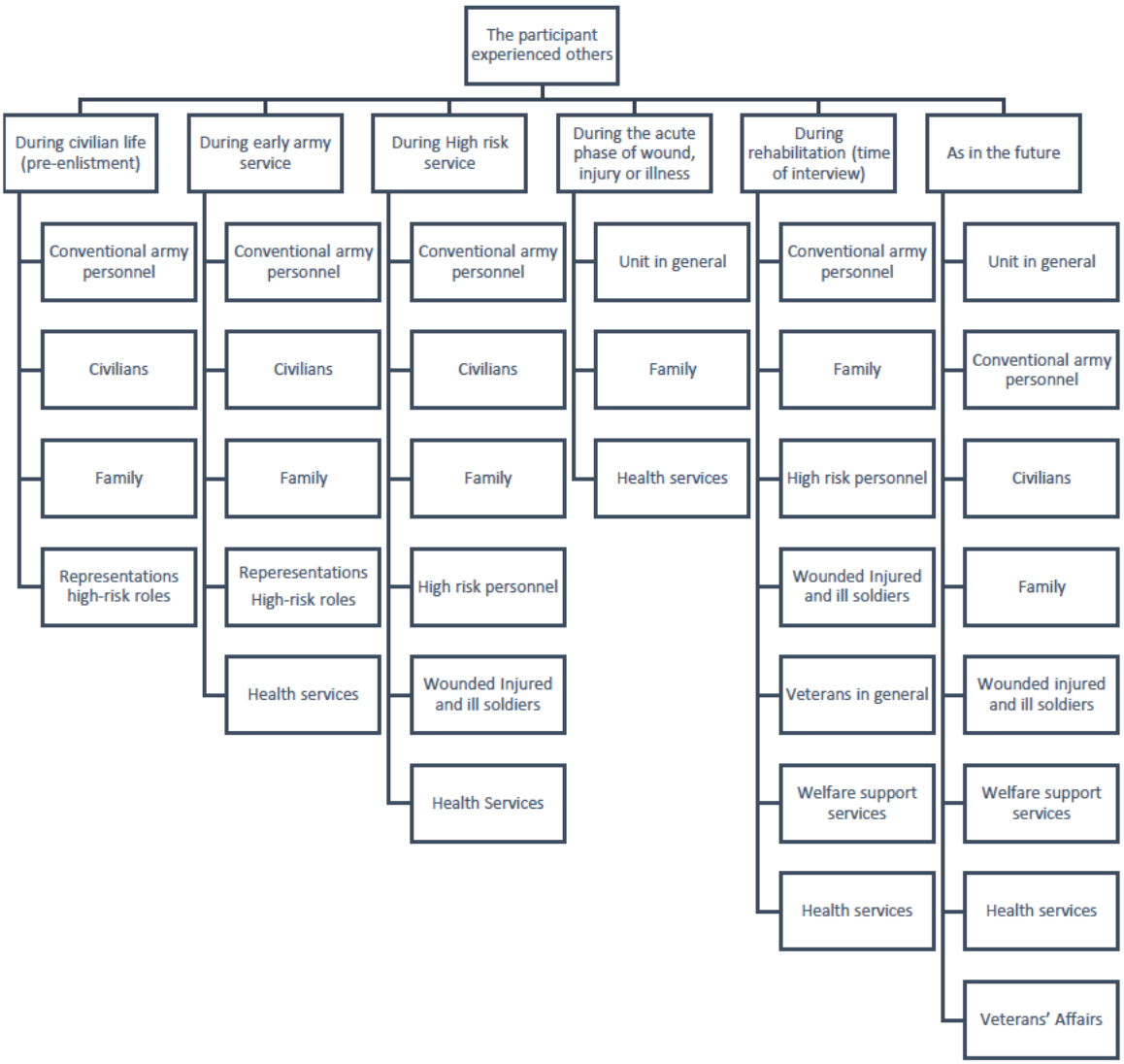


Figure 7. Other people participants talked about in the research interviews, over time

Themes were then established in relation to each dataset. Organising codes and identifying themes in this way enabled the researcher to directly compare and document the way participants came to experience *specific* others, over time.

After these datasets were established, the researcher was able to consider how themes presented independently and their relationships to other themes, including those in other datasets, thus creating an appreciation of the dynamic that existed between them, and gauging a sense of self or part-self. As an example, themes relating to ways in which participants experienced health were considered in relation to how they experienced health services, in all phases of their military career. Through comparison, the researcher was able to reflect on these, and explore the extent to which participants' experiences of health and health services interacted and thereby impacted health behaviours, such as healthcare avoidance (see Chapter 4).

2.4.5.2 Semantic and latent analysis of results

Having obtained, transcribed, coded, and themed the data, and considered these in relation to each other, analysis continued and is reported at two different levels. At a more basic level, semantic analysis was utilised (Braun and Clarke, 2006) to explicitly examine individual themes (drawn from datasets); the results of such analyses are presented as individual papers (here presented as Chapters 3 to 6)—each uniquely framed in relation to the specific phenomenon identified. In addition, latent analysis of the data is provided in Chapter 7, which draws upon a psychodynamic object relations frame to identify and interpret overarching themes—an approach increasingly utilised to help understand complex phenomenon that cannot be interpreted using contemporary approaches (Braun and Clarke, 2006).

Chapter 3. Building the brotherhood: fear and flow in combat

3.1 Preamble

This study set out to examine how high-risk combat soldiers perceive themselves during rehabilitation and transition, and the implications of these perceptions on health and health behaviours. Chapter 3 provides context to the research question by documenting the affective states associated with combat, the relationships these help forge, and the impact of these on identity.

Building upon the literature that documents the existence of affective bonds between soldiers and those in their team, this chapter provides evidence that strong affective links also exist in relation to the act of combat itself, thus binding the individual to both their task *and* their team. The examination of the affective links between the individual and their task and team, helped identify that primary group relatedness such as family, served to ultimately strengthen personal and collective confidence. Familial relatedness is also evident in the speech of participants, features of which suggest that behaviour and relating styles are similar to those of adolescence.

Although familial or primary group relatedness increased felt personal identity in the context of the collective, it also came to erode it outside that setting. Accordingly, participants reported becoming increasingly dependent on their role, which amounted to what they described as an addiction. This phenomenon has several health implications centered on the consequences of lost subjectivity and highlights the utility of helping to restore it during rehabilitation and transition. Due to the nature of the publication format of this thesis, some material presented will be repeated in subsequent chapters.

3.2 Statement of authorship

Title of paper: Building the brotherhood: Fear and flow in combat

Publication status: Not submitted

Principal author

Name of principal author (candidate): Paula Dabovich

Contribution to the paper: Conducted literature review, devised scope, aim and interview questions. Planned and conducted interviews, transcribed, coded and analysed data. Composed and wrote article.

Overall percentage: 85%

Certification: This article documents original research conducted by Paula Dabovich as a part of her higher degree by research candidature. It is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. Paula Dabovich is the primary author of the paper.

Signature: Date:

Co-author contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication in accurate (as detailed above);
ii. permission is granted for the candidate to include the publication in the thesis; and
iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of co-author: Associate Professor Jaklin Eliott

Contribution to the paper: General oversight and monitoring of research design and conduct including question design, data collection and analysis. Provided structural feedback and editorial guidance on manuscript.

Signature: Date:

Name of co-author: Professor Alexander McFarlane

Contribution to the paper: General oversight of research and provision of strategic guidance. Provided feedback on manuscript.

Signature: Date: 20/04/2018

3.3 Abstract

Background. Previous quantitative research has linked combat experience to self-destructive behaviours such as risk taking, self-harm, and suicide. This link is mediated by conditions such as affective and posttraumatic stress disorders. **Aim**. The aim of this paper is to provide insight into the subjective experience of affect in combat. **Method**. Thirteen Australian high-risk combat soldiers in rehabilitation each took part in two semi-structured recorded interviews over nine months. Analysis employed a thematic approach, within a qualitative social constructionist paradigm. **Results.** Combat was associated with heightened feelings of fear, excitement, and the euphoria of flow. In the lead-up to combat and during it, emotions were managed through intense focus on their task and having faith in the team, thus enabling mission success. After combat, the creation of shared meaning helped regulate emotions and strengthen existing bonds. Collectively, these events established a strong sense of identity and agency; however some participants came to over-identify with their role, which they described as an addiction. These results have implications for health and health behaviours during times of change such as rehabilitation and transition. **Recommendations.** Transition practices and psychotherapeutic interventions that promote personal identity and felt agency outside the combat role, is recommended. The need to acknowledge the positive experiences of combat at a clinical level is also highlighted. **Conclusion.** Combat involved extreme emotions, most of which were experienced positively. These emotions helped create a strong sense of identity and agency and, whilst functional during combat, they also held the potential to undermine a combat veteran's sense self outside this context. These findings have implications for veterans' health and health behaviours during rehabilitation and transition from the military.

3.4 Introduction

There is a strong interest in veteran health and mental health, both within Australia and abroad (e.g. McFarlane et al., 2011; Shields et al., 2016; Australian Institute of Health and Welfare, 2017). This interest has been spurred by statistics that suggest veterans are at greater risk of suicide compared to those in the community. Within Australia, the rate of ex-service veteran suicide is estimated to be up to twice that of civilians (Australian Institute of Health and Welfare, 2017) and in the USA it accounts for over 20% of total suicides each year (Kemp and Bossarte, 2013). For current serving military personnel, suicide completion rates are lower compared to the community, but rates of ideation and planning are higher, as are affective disorders and posttraumatic stress disorder (PTSD) (McFarlane et al., 2011). These

adverse outcomes of service are more often experienced by Army and Navy personnel than Airforce (McFarlane et al., 2011).

Although all personnel in the Army, Navy, and Airforce (and the Marines in the United States) are trained in combat (i.e. to use lethal force), some explicitly focus on this function and others do not. It has been well demonstrated that, compared to non-combatants, those who operate in combat roles are at greater risk of mental health problems (over time), due to the cumulative exposure to traumatic stress. These problems include higher rates of suicidal thinking and self-harm behaviours (Maguen et al., 2011) and are understood to be mediated by symptoms of PTSD and affective disorders such as depression (Maguen et al., 2011). Combatants, in a contemporary context, also have higher rates of PTSD, anger, relationship problems, and alcohol abuse (Maguen and Burkman, 2013; Maguen et al., 2010), along with increased rates of violence directed not only toward themselves, but also toward others (MacManus et al., 2012; Svetlicky and Lubin, 2010; Thomsen et al., 2011). Similar patterns have been observed in those who served in the Vietnam war, decades after their combat experience (i.e. Fontana, Rosenheck, and Brett, 1992; Gimbel and Booth, 1994; Maguen et al., 2012; Maguen et al., 2009; Ruger, Wilson, and Waddoups, 2002). Some have argued these outcomes may be, in part, a consequence of individual genetic predisposition and prior trauma exposure, for example, in childhood, although twin studies consistently show that combat is causative, not genes (Gilbertson et al., 2010; Goldberg et al., 1990; Roy-Byrne et al., 2004). In addition to these behaviours and perhaps compounding them, evidence indicates that veterans underutilise or avoid healthcare services that may otherwise help them manage these vulnerabilities (Hoge et al., 2004; Jakupcak et al., 2013; Pols and Oak, 2007).

The link between combat roles and the outcomes described above have been extensively investigated. Studies reporting on these typically present data collected from large populations using quantitative methods such as surveys, scales, questionnaires, and retrospective analysis of post-operational mental health screens. This quantitative approach has identified a link between combat experience and negative health outcomes compared to civilians and non-combatants, but it does not account for the subjective experience of combat or trauma, to which these outcomes are often attributed. Accounts of this can be found in qualitative analysis of historical letters and diaries (e.g. Bourke, 2000; Etter, 2005; Jones, 2006), and in extended texts offering case studies and personal insight (e.g. Grossman, 2009; Grossman and Christensen, 2007; Lifton, 1973; Loyd, 2014; Nadelson, 2005; Shay, 2003, 2010). There is, however, a paucity of recent academic literature that specifically explores and analyses subjective accounts of combat using theoretically-framed interviews. This is important

because such information is increasingly valued in healthcare planning, communication, and promotion (Marks et al., 2000).

There are some writers that have explored subjective accounts of combat such as Jensen and Wrisberg (2014) who used interviews to explore the skills, performance, and coping behaviours associated with hand-to-hand combat (i.e. that which involves intimate proximity and physical contact between combatants). The data obtained from this study was analysed and used to help soldiers train for future performance. Purcell et al. (2016) undertook interviews and focus groups to examine psychosocial consequences and moral injury over time. Participants in this study were interviewed many years after combat: some "within a decade" and most up to "several decades" after it (2016, p. 1067). Whilst providing evidence of long-term effect, this does not account for recent experience. Interestingly, although neither of these studies specifically aimed to explore the emotions of combat, they featured in the results. The former reported mostly negative emotions, and the latter more positive ones such as excitement and euphoria.

A further study elicited data from five Vietnam combat veterans who were suffering from hyperarousal, re-experiencing, and sleep problems, along with feelings of detachment, future foreshortening, and poor quality of life (Nadelson, 1992). Results pointed to a relationship between combat, affect, attachment, and addiction. There were some limitations to this study. First, like Purcell et al. (2016) the study was conducted decades after combat, and as such recollections of it were temporally distant. Second, the methodology was described only in terms of video-recorded, in-depth interviews, and thus the means of analysis is not known, with insufficient information provided to allow for an assessment of the rigour of the analysis (for a comprehensive account of assessment critera, see Tracy, 2010; Liamputtong, 2013). Notwithstanding the limitations of these studies, emotions were reported to feature strongly in all, and, given that risk-taking, self-harm, and suicide are linked with affective disorders and PTSD in this population (Maguen et al., 2011), specific examination and analysis of the subjective and emotional experience of recent combat seems called-for. This paper aims to address this need.

3.6 Participants and method

The study from which this data and analysis was derived was accepted and approved by the Human Research Ethics Committees of the Australian Defence Force and the University of Adelaide. A qualitative, contextual approach positioned between social constructivism and critical realism was adopted (Braun and Clarke, 2006; Willig, 1999), and analysis employed thematic techniques (Liamputtong, 2013) to develop insight into the subjective experience of

combat military personnel undergoing rehabilitation for service-related injuries and illnesses. This approach was chosen because it allows for a realist position that accounts for military structure but also enables reflection on how the areas of interest shape the social reality of participants.

Recruitment occurred through a senior high-risk combat soldier, who initiated a snowball method amongst his *brotherhood* (a term used to denote the close relationship between participants). This occurred after unsuccessful attempts were made to recruit through unit-based healthcare professionals, with whom participants were reluctant to engage. The change in recruitment strategy was approved by the relevant ethics committees and enabled successful recruitment that continued until data saturation. This occurred at 13 participants wherein no new themes related to the research aim were identified (Fusch and Lawrence, 2015). All participants were male and ranged in age from 32-39. At the time of writing, combat roles were available to females, but none had been employed in this capacity. Participants were recovering from for physical combat wounds (n=8), physical injuries (n=3) and psychological injuries and illnesses (n=2). Each participant took part in two in-depth, semi-structured interviews by the primary investigator. Each interview lasted approximately two hours.

The first interviews enabled themes to be identified, and the second provided further insight into the themes. Themes relating to the first interview were reviewed by the second author, with variances in interpretation resolved through discussion. Themes were further validated by participants who were given the opportunity to check for accuracy (Bygstad and Munkvold, 2007).

Although interviews were designed to evoke dialogue around the biopsychosocial elements of participants' health and well-being, during analysis of the first series of interviews, it became apparent to the research team that the combat role was very important to participants' sense of health and well-being. Questions designed specifically to elicit talk about emotions involved in combat were included in the second series of interviews. This involved the caveat of reminding each participant that they need not answer questions if they chose, along with sensitive interviewing techniques that incorporated time for silence (Eliott, 2006), pausing the interview when necessary, and renegotiations as to whether they would like to continue. In addition, contact details of available psychological support services were provided to each participant prior to the commencement of the interviews.

All participants chose to talk about their combat experiences. Questions included "what does it feel like in the lead up to a fight?", "during it?", "after?", "what's going on around then?",

and “can you tell me more about that?” As some participants appeared comfortable with, but struggled to find words with this line of questioning, the interviewer offered the option for them to complete sentences (Donoghue, 2000). As an example, the question “what does it feel like in the lead-up to a fight?” evolved into “Can you complete this sentence? ‘Going into a fight, I feel …’”. This enabled many participants to more readily express their subjective experiences.

Most interviews were conducted in a private office within a community facility, located near the participating unit; some participants preferred to be interviewed in or near their homes and during the second interviews, two were interviewed via telephone due to operational demands. All data were audio-recorded and transcribed verbatim, with non-lexical speech elements such as “err,” “ah,”” and “um” removed for ease of analysis and reporting (Stiles, 1992). Identifying information was changed during transcription, to protect participant identity. The text was imported into NVivo (QSR International Pty Ltd, 2012) and analysed.

Some statement is needed on the dual role of the primary investigator. As a military officer, she could be deemed an *insider*, because she was conversant in military language and held a degree of cultural insight—characteristics that enabled her to connect with and be taken seriously by participants. Even so, being female and in a health researcher role, she was also an *outsider* (Dwyer and Buckle, 2009). Anticipation and mitigation of perceived or potential real power imbalances were outlined in both the military and university ethics applications, and observed during the course of the study.

3.6 Results and analysis

This study aimed to explore emotions associated with combat and consider these in relation to higher rates of affective disorders, PTSD, and suffering experienced by combatants. Participants discussed their experiences in extreme terms. They talked of the great privilege of operating on the world stage, as well as the build-up and release of combat-related tension. Tension build-up occurred in the anticipatory phases of combat and was characterised by feelings of intense fear and excitement. Its release was imbedded in the euphoria of combat which was followed by a comedown. At this time, bonding occurred between participants and their peers, wherein close relationships were forged through co-validation and the creation of shared meaning. This served to regulate emotions and it increased the levels of trust between participants and those they came to call *brothers*. The cycle of tension building and release, was both generated and reinforced by mission success and led to what some participants called an “addictive environment”.

3.6.1 Mission success: survival and impact

Mission success related to meeting two objectives: to survive, and to have impact. Survival, in the context of participants' combat role, was also interpreted as collectively winning the fight, or at the very least, losing less in it.

> A lot of guys compare it sport … but if you lose, you die. *(3.1)*
>
> … if you have guys who are killed or those who are wounded, … we have killed way more of them [the enemy], than they have killed of us, exponentially more. So you can take that away from it. *(3.2)*

The latter idea of winning as more "guys" surviving, or sometimes simply losing less than the enemy (through wounding or death), points to the value of the collective over the individual, indicating that the mission took priority. Success was also associated with team impact on the broader mission, and on those they were charged to protect and serve. Many associated impact with the felt privilege of their role.

> … that feeling of accomplishment that ops [operations] can only bring. When you are actually helping somebody and making a difference in their life. … [When I was] sent to Iraq, [local] people had issues with security, you know, getting hassled. People around them are getting killed. Just to provide that security for them and for them to go about their business in a safe manner. Again, that feeling of accomplishment, … being happy for their success. *(3.3)*
>
> [It is a] nice feeling doing things that most people can't, or won't ever get the opportunity to do. … You feel … privileged to be in that situation. *(3.4)*
>
> When you are involved in the [defeat] of people who desperately deserve to [be defeated] is an absolutely great feeling, … that's as good as it gets. There is a massive feeling of accomplishment when bad people [are defeated]. *(3.5)*

Mission success, earlier described as collective survival—"we have killed way more of them than they have killed of us" *(3.2)*—and here, as having an impact on the broader mission and on the lives of others by "making a difference" *(3.3)*, was experienced personally and collectively. At a personal level, participants associated success with a sense of privilege and accomplishment which may be understood as contributing to their self-esteem. Mission success also contributed to collective esteem, recognised and validated through unit awards and citations.

> It's not just the survivability, but the collective success. The outcome of the collective effort and risk. … The drive isn't to just to fight [partake in combat], the drive is to have an effect. … Culturally it is important to pride yourself on being good combatants and good soldiers, … validation wise, it is really important for things like unit citations of gallantry and battle honours …because it recognises the collective. Individual awards are quite frustrating because they are rarely reflective of reality, where those collective awards are probably more adequate and true validation … the collective strives for collective success … It is not selfish, it is selfless. Most people are here to serve a selfless end-state. *(3.6)*

This speech of "collective success" is indicative of the values that underpin organisations driven by a service ideology: that is, to become "selfless" and to serve the greater "good" *(3.6)*.

Participants were, for the most part, motivated towards operations to achieve mission success which was understood as collective survival and impact. Mission success positively influenced personal and collective esteem. Participants also talked about the simplicity of filling an operational role, contrasting this with the 'dramas' of everyday regimental life.

> You wake up, have breakfast, you might do confirmatory orders, you go back, and put your gear on, you line up, you get on a chopper, go out. As a group, kill … [several insurgents], you come back, you have a shower and watch Dexter on your laptop; go to the gym. Then you do it all again the next day. … There is no worries. There is no dramas. You don't have day to day dramas that you have back at the Regiment. You don't have any of those worries. Very simple. If you are an operator, your job is very, very simple… For us it's simple, because it is all we know. *(3.7)*

Although described a "simple," and free from "worries", the role of an operator, or a high-risk combat soldier, was paradoxical, as operating in extremely unstable and dangerous environments was associated with high demands, and with fear and the excitement of the unknown. It is to these we now turn.

3.6.2 Fear and excitement of the unknown

In discussing the lead-up to and anticipation of life-threatening combat engagement (e.g. movement into unfamiliar and unknown situations, preparing for entry to an enemy-held building, or during transport to a known target) participants spoke of extreme emotional arousal characterised by fear and excitement: "... you are as scared as you can probably imagine. [it's like] if you [are] just about to see a car head on to you, but you are still enjoying it." These high levels of arousal were also physiologically evident: participants talked about changes in their bodies, attributed to adrenaline. These included an increased heart rate, dry mouth, and feeling "jittery."

> If you know it is imminent, and you know it is going to happen, you are very jittery, like butterflies because you have the adrenaline built up in your stomach. You are feeling jittery and you are scared. *(3.8)*

> Sometimes you don't know what it is going to be. Sometimes you do an advanced contact [a tactical manoeuvre] where you get an anticipatory heart rate … it starts to happen before you are there. *(3.9)*

> Everything about it is exciting. Heart rate. Dry mouth … it is absolutely exciting. *(3.10)*

> It's a whole bunch: the adrenaline just keeps picking up, the endorphins, through a mixture of fear and trepidation. *(3.11)*

Participants also talked about the means they used to manage being 'scared' (experiencing fear) so as to enable continued movement toward danger. This involved blocking the present and any dangers inherent to it, often by focusing on the task.

> Your feeling is quite a numbness. Just thinking about the task at hand and cracking on. *(3.12)*

> You are walking along going "I could detonate right now", I am 100 metres from a house. … If I was going to put an IED [improvised explosive device] somewhere this is where I would f**king put it. So you think, "Am I going to detonate?" every time you put your f**king foot down. But you try to get that out of your head. … But so long as you can keep that s**t out of your head and stop thinking about "am I going to f**king detonate?" You are thinking about the tasks, thinking about the orders you have been given, so keeping on track. *(3.13)*

> Beforehand, it can be quite daunting. It's the same with the theory of parachuting where you do all these stupid drills, that are totally irrelevant, but keep you busy so that you are not thinking about being scared. You have got no time to overthink anything and stuff like that. … Your 100% focus is on preparation. You are not putting energy into emotional or physical dilemmas, or fear, or anything like that. *(3.14)*

These passages suggest that shifting focus from the self and directing it toward the task was central to emotional management prior to combat, supporting the earlier claim that participants focussed on "collective success" or a "selfless end-state." Highlighting the importance of an outward focus, that is, on the task at hand, the consequence of looking inward and thinking about the self was associated with succumbing to fear, freezing and dysfunction:

> … your 100% energy or focus is on doing your job. I guess, the point where you see people that freeze or don't function … they capitulate fear or a reallocation of their effort and cognitive [cognition], to fear and preservation, rather than what they are supposed to be doing … I am fairly happy that has never happened to me but I have definitely seen people … the fear and self-preservation does become a higher priority in themselves rather than fighting or whatever. It is unusual, but it isn't non-existent, even in this sort of place. *(3.15)*

To maintain focus on the task amidst dangerous and unstable environments, and to avoid succumbing to fear, freezing and dysfunction, participants drew on the faith they had in their task, their team, and the faith others had in them. The importance of faith was expressed explicitly, and again a focus on the self, rather than on the task or 'plan,' was associated with lost faith.

> … the hierarchy … they have faith in us to send us out and do what we got to do. *(3.16)*

> … because it gets to that point where you know you can rely on yourself and the other guys [so] … when it happens, you can go straight into that mode of dealing with it. *(3.17)*

> [This] happened on a mountain in a small team, side by side. One guy was saying this is amazing and this is the best and the other guy was saying I just want to get home to the kids. … [The first] guy knew what was happening and he believed in the plan and he believed in the support, and all that sort of planning prior to, that it was going to come off. And the other guy just absolutely thought negatively and thought "no, it's all gone to s**t, and I want to get out of here", sort of thing. *(3.18)*

Pre-combat fear was therefore associated with the uncertainty of the unknown, and was managed by focussing on the task, and by having faith in the team. These ultimately served to provide a degree of psychological organisation and personal control in the face of uncertainty. For most, maintaining focus on the task and faith in the team required considerable cognitive and emotional effort, which was, however, relieved on enemy engagement.

3.6.3 The switch

Typical of asymmetrical warfare, participants described their enemy, who were insurgent forces, as relatively unknown in their areas of operation, and this 'un-nerved' them. In and upon enemy engagement, however, (i.e. when the enemy provoked or attacked) participants uniformly talked about the experience of a switch: "If you all of a sudden get in contact, the switch is on."

> You have very little choice often over when you are going to fight. Apart from you going there and being present, when and what happens is almost entirely in your enemy's hands. *(3.19)*

> Once it has started, you know where everyone is. You know where the enemy is; you've got a plan. It's almost like, when you are going into a fight, there are so many variables that you don't know. Until the enemy unmasks themselves. As soon as they start shooting it's fine. If you are walking through a village or whatever, into a building… and you don't know where they are … that silence … it's pretty un-nerving, but once the shooting starts, it's fine … a relief. *(3.20)*

This 'switch' may be understood as a changed position of power in relation to the enemy. As described above, choice (i.e. about the time and place of combat), and thereby advantage and power, typically belonged to insurgent forces; on contact (i.e., when the enemy engaged), these switched to participants' teams, rendering enemy forces more vulnerable. The switch, as a change of position, was also experienced as an internal change that involved cognitive disengagement and emotional detachment on one hand, and extreme agency on the other. The use of the word detachment here is important because emotions, particularly that of fear, did

not disappear per se. Instead they became separated from the participants by way of the task, and completely subjugated by it.

> And there are other times where there might be a second of fear or panic as you hit the ground or take cover, and your actions from there become deliberate and clear, and you know what you want to do. *(3.21)*

What disappeared upon activation of the switch were the thoughts and emotions *associated* with pre-combat, thus allowing combat itself to be experienced calmly.

> You are in the chopper, there's that nervous energy before you get there and you are waiting and you're waiting and then "BANG!" and then it's like "ahhhh, it's on." It's good. Everything is like: "I'm calm" and you do what you got to do. *(3.22)*

3.6.4 The euphoria of flow

Some participants had difficulty describing combat "I don't know that I can [describe it]. I don't know how to put into words to be honest," and "You know what? I don't think there is emotion. It is not happiness. It is not fear. It is not sadness. It is none of those." Nonetheless, most spoke of it as a cascade of clear, calm, and deliberate automation, previously primed through training.

> There is a calm feeling … the training is instinctive … the more exposed … the more comfortable you become in that situation. *(3.23)*

> … you don't have time to fear anything because you are decisive and clear about what needs to be done, because you've trained for those drills and then you get on with it, and do it. *(3.24)*

> When you are in a really life-threatening situation, close combat … there is almost an autonomous side to it. … I did things out of instinct and training … Everything [was] happening [in a] slowly kind of mental state. *(3.25)*

As suggested in quote *3.25* above, some participants experienced time distortions in combat which may indicate a degree of dissociation. However, whilst some spoke of slowing down, others experienced themselves as moving faster than what was later evidenced.

> When I got shot from behind … I felt I was moving so quick … [when I watched in later] on someone else's helmet cam[era], I am struggling up this hill: too heavy, too steep, too hot, too thirsty. It is kind of funny. You know how it felt, and then you look at it … it doesn't look as cool as I thought it did. *(3.26)*

Individual automation was complemented by extreme interdependence and inter-predictability to ensure mission success. "Your move dictates the next person's move so you are highly interdependent at that time in a way that needs to work predictably." This may be usefully understood as synchronicity and further highlights the focus participants had on their role as a

part of the team. Automation and synchronisation were distinctive from robotic action, because for most, it was accompanied by the very human experiences of feeling fully alive with an immense sense of belonging in both time and space. This was further described in terms of flow and euphoria.

> It's a sense of flowing achievements... You are just humming… *(3.27)*
>
> And then when are in it [combat], it is like euphoria. *(3.28*)

> I had this feeling that … I should be nowhere else on earth except doing this right here, right now. A feeling of belonging, such a huge rush. It was so exciting. *(3.29)*

> I suppose you feel alive … it feels good, if you know what I mean, to be doing what you are trained to do with your mates. *(3.30)*

At the extreme, the felt sense of belonging that came with "doing what you are trained to do with your mates" (3.30) was symbolically described in symphonic terms.

> If you equate it to an orchestra or band and how it works together … it is like that; where you are doing something, this goes with that, and matches perfectly. And then something else comes in … it's like a symphony… It is not a juggling act because juggling's out of control, it is a symphony of different skills coming together. *(3.31)*

Movement from the unknown to the known, from vulnerability to power, and the engagement in combat with a team who is synchronised and powerful, may be considered a peak state, also described as self-actualisation (Maslow and Arieti, 1961) and flow (Csikszentmihalyi, 1990).

3.6.5 Changes over time

Despite the peak state associated with operations and combat, for many participants, these had not always been experienced positively. Most participants talked about early career combat as a state of confusion and sensory overload, and for some this resulted in loss of those specific memories. Over time and after repeated exposure, however, their experience of combat came to represent that previously described.

> The first few gun fights I was in, I can't even remember them. I can't remember them. As you go on, you go "s**t that was pretty dodgy", the whole dynamic changes a bit. *(3.32)*
>
> … my first four or five contacts, it is sensory overload. You don't remember much… All you remember is "holy s**t we are getting shot at!" "Where is it coming from? Where do I go to take cover?" … The further you get into it, sensory overload diminishes and you get a widening of awareness. You are now hearing rounds but you are hearing the kind of sound it is. And you know if you have a crack or whistle of air near you, you know they are not near you so you don't stress out. You can hear it, you know it's happening, you might move and go to cover, but you are not focussed on getting to that rock. It is [in a very calm

> and robotic voice] "I have got to go there; that's happening there; where's the rest of my team?" *(3.33)*

The last passage suggests that, over time, participant focus changed from individual survival with internal awareness in early engagements, to the external awareness necessary for collective survival. Speech shifted from focus on the self "Where is it coming from? Where do *I* take cover?" to that of the task and the team "I have got to go *there*; that's happening *there*; where is the rest of my *team*?" (italics added).

The sensory experiences of combat and focus on survival were not the only things that changed over time. Participants also came to experience themselves as more confident and this related to an ever-increasing sense of identity. This was mediated through successful role performance and validation by the team.

> It is a validation among your peers but it's also something where you can say, "Yeah, I can do it." It is something validating because … when you do get over there, it's like "S**t, I hope I am actually up for it". I don't know what it's going to be like the first time I get shot at or I'm in a gun fight. *(3.34)*

> My first trip was heavily kinetic [involved ongoing enemy engagement], … you are young and it's an exhilaration and you are craving that validation of your skill set, and your worth, and your abilities and that sort of stuff. *(3.35)*

> Taking somebody's life, it's funny because the first time you shoot someone… It's like "oh f**k, I just killed that guy, oh f**k". But by the end it's just like, f**king hell, you don't even think about it because you are bouncing off the team. *(3.36)*

The last of these quotes suggest that the confidence (or sense of agency associated with their role) that came with increased identity, was also related to changed focus, where the experience of combat became less personal and more team-based. In this case, the experience of killing someone initially prompted personal reflection "oh f**k, I just killed that guy" but eventually it was described as an issue not personally reflected upon, but rather validated and reflected back by the team: "by the end … you don't even think about it because you are bouncing off the team."

Furthermore, validation in and amongst peers, was spoken of as significant to this population. It appeared in earlier speech (see quote *3.6*) about collective awards and citations, and, in *3.37* below, it was described as critical to individual psychological survival:

> … even within the lulls within the fight, when you might fight your way into a compound, you clear it, and have a bit of a pause and have a drink, and get your breath back. It [validation] can, to a low sort of degree, start from that point where you positively validate each other's actions ... I think that is psychologically important for people that have to do things that are nasty, or

> unpalatable, or hard to deal with, or traumatic, or whatever. To have validation from your peers that that was the right thing. I think that is important. *(3.37)*

Validation from peers, therefore, served as a means of mutual support as participants sought to justify the "nasty, unpalatable, or hard to deal with, or traumatic" reality of what it took to achieve mission success. This validation also served to bond participants to each other through the creation of strong relationships.

3.6.6 Bonding the brotherhood: creation of shared meaning

Participants talked about co-validation within their team as critical during combat and after it. This validation came to form the basis of making collective meaning of events, which included clarifying individuals' roles in them. This process served to develop a narrative of events that could be integrated into personal and collective memory; this in turn appeared to work to bond and attach participants to each other, and to regulate their emotional responses. Bonding and the creation of shared meaning were achieved through various forms of replay, such as storytelling and watching footage of the recent combat:

> There is also the feeling of the people that you are doing it with. It is good to be with a really tight group and even if they're not at a tight level they will be tight, in a few moment's time, sort of thing. They will be very, very close as a result. And afterwards, that comedown of the adrenaline. Everyone does get closer. Everyone shares stories and it is a great feeling. *(3.38)*

> You are with each other and you are like "did you see that? Yeah! I did that, and you did that, and you did that, awesome thing, and yeah, you nearly got hit. You see that thing hit right next to your head?" and you know, you debrief all that stuff in a positive way. I think that is infinitely important and I guess from a psychological perspective, right from the minute. It was almost like "we did good" because it is just such a heightened sensory experience. It was like "whoa, how was that?!" You know? I guess people like to share those heightened experiences. Even though, to the normal civilian, they would go "that's mad" because people are shooting at you. *(3.39)*

Such bonding was further enhanced through participants' awareness and articulation of shared success in spite of near impossible odds, and through experiencing hardship.

> After that particular battle, the boys were on the chopper on the way out, hugging each other: "how the f**k did we survive that?" but that's very rare. That type of battle, the guys were making entry to rooms and shooting around women and kids [so as to avoid harm to the women and kids] to kill the insurgents who were using the kids as human shields [thus protecting the civilians]. That's pretty crazy. That's pretty intense stuff. *(3.40)*

> It's the hardships that bond. Without a doubt. If you walk a thousand miles with a dude, you are going to bond with him … because it's just that hardship. War is hardship. Walking up big hills. Getting shot at. *(3.41)*

> On a more unfortunate level, is experiencing misfortunes together … [it] brings it [the team] tighter … it adds to your level of trust. That you can depend on each

> other, no matter what. You give more faith to each other, on the same grounds. It is the same for good experiences as well. *(3.42)*

In sum, the experiences of co-validation, shared meaning-making, and bonding served to regulate individual emotions and strengthen relationships with those participants came to call *brothers*.

> These guys are like, brothers by choice. You love these guys with man love, and you love this [biological family members] as in real love. So you care about the welfare of both groups. *(3.43)*
>
> One of the guys put it really well and he said "I wish I could just bottle this feeling" … just that sort of brotherhood. Just being on a high. A natural high … Everyone is alive. *(3.44)*

The term "being on a high" employed in the quote above also gives clues as to the mindset that developed in some participants, as they came to experience combat as an addiction.

3.6.7 Combat as an addiction

Participants overtly valued much that was experienced in operations—the success, the simplicity, intense emotions such as fear, excitement and euphoria, along with the strong bonds created after it—as well as the consequent sense of a strong identity with an increased sense of confidence. There were further indications within their speech that suggested that some participants came to over-identify with their role in which they gained a felt omnipotence, and became addicted to it. Some also seemed perplexed by the lack of attention afforded to the phenomenon in veteran health discourse, for example, one participant put the question of addiction to the interviewer thus:

> I don't know if this [research interview] is the right forum, but is certainly something which has been on my radar, is this idea … about guys that are addicted to war. [I] imagine people in the past have struggled with it, but maybe it has gone under the radar and it is not something which has been spoken about or detected. Or it has been passed up for something else. I heard on the radio today they were talking about it as "after the applause syndrome". This is a civilian thing. Famous people who get up in front of big crowds and footballers or whoever—they get this big rush from being in front of a crowd, and being a big stage, and then when they retire and finish up, they can't fill that gap and they can't find that adrenaline rush again. That's the same I think with soldiers. I love my job and I thoroughly enjoyed doing what I did overseas and it is going to be hard to fill that… transitioning, … when that day does come to transition, it will be difficult. *(3.45)*

This participant had reflected deeply upon the issue of combat addiction, predicting the difficulties it would pose on transition out of the job. Others, however, talked about it more casually, and as something taken for granted and self-evident.

> You get addicted to what your role is and what you have to do; and I suppose the addictive part is success. Success is what your mission is. *(3.46)*

> If you are doing things every night that are arduous and you are walking long distance and you are doing things that are above comprehension of 99% of people on the earth, that is part of the addiction as well. *(3.47)*
>
> It is an addictive environment, I guess. Even though sometimes things don't go as planned. … The more you do it—for the large majority of the guys and for myself— the more you want to do it. *(3.48)*

It is evident that these participants strongly identified with their combat role which existed within a collective, and was simultaneously experienced with detachment from the self. This strong identification is not surprising given the self-less *task and team* mindset required for survival and mission success.

3.7 Discussion

Given that combat is a risk factor for psychological disturbance such as posttraumatic stress disorder (Osório et al., 2017), results suggest some divergence between academic understandings, and the lived experience, of combat for these participants. Participants described the subjective emotional experience of combat in heightened terms. These emotions included fear, but the overall memory of it was dominated by excitement, extreme focus and, euphoria, as well as the strong bonds consequently forged after it.

Although fear was specifically associated with movement toward danger, within environments dominated by enemy forces, it was managed by maintaining focus on the task and by having faith in the team, which required emotional and cognitive effort. On enemy contact, this effort switched to the experience of flow, expressed as personal automation and team synchronicity, and euphoria. Combat was swiftly followed by a comedown wherein bonding occurred through co-validation and the creation of shared meaning, which in turn, helped to regulate emotions. It is not surprising then, that combat provided a platform for the creation of a strong identity and came to be experienced positively. However, participants over-identified with their role, which they described as becoming an addiction.

Although combat was associated with addiction, participants acknowledged that it was sometimes "nasty … unpalatable … hard to deal with … [and] traumatic," none linked their suffering (see Chapter 5), directly to it. On the contrary, participants spoke of combat (for the most part) as an optimal experience, rather than a traumatic one. Optimal experience, such as outlined in the results of the current research, is understood in the psychological literature, as *flow* (Csikszentmihalyi, 1990; Nakamura and Csikszentmihalyi, 2014), described as:

> … a state in which action follows action according to an inner logic which seems to need no conscious intervention on our part; we experience it as a unified flowing from one moment to the next, in which we feel in control of our actions,

> and in which there is little distinction between self and environment, between stimulus and response, or between past, present, and future.
>
> Csikszentmihalyi 1975 in Turner (1979, pp. 486-487)

Flow may be understood as a liminal state that brings about a positive change in the way people experience themselves (Turner, 1979). It is a conduit to personal growth and creation (Baker and MacDonald, 2013; Garces-Bacsal, Cohen, and Tan, 2011; Perry, 1999) that facilitates a sense of order, control, and identity (Mao, Roberts, and Bonaiuto, 2016; Orta, Sicilia, and Fernández-Balboa, 2017). Flow is also related to agency in that it merges the person with their actions, wherein they successfully make something happen (Csikszentmihalyi, 1990) and thereby increase their confidence in the world.

Flow usually occurs under certain conditions, all of which were present in the combat experiences of participants. It is said to occur when an individual uses an acquired skill in a strongly bound and challenging environment (Csikszentmihalyi, 1990). In the current research, participants used their skills and training in the context of their role, which both framed and dictated their actions. Significantly, flow also demands immediate feedback (Csikszentmihalyi, 1990). This featured prominently in the speech of participants through the realisation they had survived and won in intense and life-threatening circumstances, and through co-validation, described by participants as critical to wellbeing. Clearly for these participants, there was an exhilaration in flow, implicit behaviour, the execution of learned skill, confidence and mastery in the context of survival and mission success despite life-threatening situations. This phenomenon is under-explored within the academic literature.

Flow may be conceptually similar to that of perceptual (or implicit) memory (a concept imbedded in neuroscience) wherein long-term representations of significant emotional experiences (particularly those of visual and audible nature) are created and stored in the brain as *sensation-near representations*. This process, and parts of the brain involved (namely the amygdala, insula and dorsal visual stream) are “specialised for action on the environment” (Brewin, 2014, p. 20), perhaps reflecting the ways in which mastery or agency is achieved. In this study, sensation-near representations (of training and previous combat) are both *used* and further laid for future automatic (and usually effortless) recall—a process known as priming (Brewin, 2014). Perceptual memories are understood to work alongside, and even enhance, episodic (or explicit) memories that can be voluntarily recalled and verbally expressed (Brewin, 2014).

For participants, recall of intense combat involved a range of other emotions beside fear, emotions that gave rise to confidence, implicit decision-making, and the reward of an

understanding of their own capacity. Collectively, these helped shape a very different account of events more typically understood as traumatic.

Although these elements of perceptual memory, here experienced as flow, are central during combat, they are not unique to it. They also occur in civilian roles related to performance such as sports, music, and art, all of which demand emotional investment, and often result in personal growth (Baker and MacDonald, 2013; Drane and Barber, 2016; Garces-Bacsal et al., 2011; Orta et al., 2017). It is worth noting that, although flow was popularised as a psychological phenomenon by Csikszentmihalyi (1975) in the mid-1970s and drawn on by sociologists such as Turner (1979), the concept previously featured in the work of developmental and humanistic theorists. Winnicott (1942) described similar phenomenon as elements of play, while Maslow and Arieti (1961), Erikson (1968), and Modell (1968) specifically wrote of such states as a means of identity formation. Central to the observations and proposals of these writers is the idea that states of flow are creative and unifying acts of self-discovery that help to connect and consolidate identity, which in turn, contributes to subjective states of wellbeing (Erikson, 1968; Meares and Lichtenberg, 1995). This has been extended in a military context by Harari (2008), who postulated that flow in the armed forces contributes to individual wellbeing and combat performance.

In the present study, flow and its associated perceptual memory state were associated with a degree of focus that enabled calm, decisive and clear action in extremely unstable and dangerous situations, which was necessary for mission success, regardless of individual outcome. Participants' identities therefore, were created precisely through having little regard for their personal sense of it, with focus being acutely directed toward the task and the team. This is an identity based on courage (McGurk and Castro, 2010; Rachman, 2004), that may also be understood as self-attainment based on self-detachment, with perhaps a degree of omnipotence.

Notwithstanding the positive characteristics of flow as a conduit to implicit mastery, identity, and wellbeing, in the extreme, flow may be problematic in that it can result in detachment from other parts of life and resources that may be critical to *sustain* identity outside the context of the activity (Csikszentmihalyi, 1990; Harari, 2008; Schüler, 2012). In this study, flow narrowed (i.e. focussed) emotions and awareness precisely to the individual's role, as it related to the task and the team. Though highly functional in context, this may be one of the mechanisms that contributed to participants' decreased ability to tolerate the ambiguities of everyday life, both personally and socially:

> The flow experience is typically described as involving a sense of control–or more precisely, as lacking the sense of worry about losing control that is typical in many situations of normal life. What people enjoy is not the sense of *being* in control, but the sense of *exercising* control in difficult situations. … while experiences are capable of improving the quality of existence by creating order in the mind, they can also become addictive, at which point the self becomes captive of a certain kind of order, and is then unwilling to cope with the ambiguities of life.
>
> Csikszentmihalyi (1990, p. 4)

To help understand the impact of flow in this context, we again return to the developing theory regarding perceptual memory, which may underpin the flow state. Previously, the process of priming was presented as a process that both used and laid down sensation-near representations in the perceptual memory, the recall of which becomes increasingly effortless and automatic with each exposure (Brewin, 2014). These perceptual memories are currently thought to exist in separate representational structures to the types of memories that involve selective conscious recall and verbal accounts of events *(such as when and where).* Rather than being stored as sensation-near representations in the perceptual memory, selective memories that can be verbalised are stored as *contextual* representations (C-Reps) (Brewin, 2014).

While there is evidence that engagement of perceptual memory can enhance episodic memory, there is also increasing evidence that it can also dissociate from it. Under this circumstance, emotional and sensorial-laden perceptual memories may begin to break-through (i.e. intrusion of affect) and overwhelm episodic ones, rendering the latter vulnerable to increasingly unpleasant states of fragmentation and disorganisation, the tolerance of which may become increasingly effortful (Brewin, 2014). It is possible then, that the potential dysfunction (as described by participants and Csikszentmihalyi, 1990) may result from highly primed perceptual memories that fragment episodic memories, which then become increasingly uncomfortable to bear. It is this type of memory dissociation and subsequent intrusions, that some attribute to conditions such as PTSD (Brewin, 2014; Bryant et al., 2011)—a condition understood to disrupt identity (Brewin, 2011).

In psychosocial terms, addiction occurred when participants no longer experienced themselves as *the subject* that filled a role (that framed and enabled flow), but increasingly as *subject to* that role and thereby dependent on it. Such narrowing of experience may be understood as a shift in self construct, wherein the individual self becomes diminished, externalised, as well as more dependent on the role (or the conditions the role brings about),

and validation from others. Meares and Lichtenberg (1995) have similarly described the psychic response to the loss of subjectivity as it becomes externalised, thus:

> The development of self is impeded and the individual's processes are dominated by a linear, externally directed form of thought. He or she lives as if addicted to the stimuli of the outer world … no sense of wellbeing can be gained … the result is "fragmentation" and a loss of personal continuity.
>
> *(p. 62)*

Whilst the events of combat can be held in an exhilarating state of mind or perspective, they clearly do not necessarily protect the individual from the trauma that occurred. In parallel, whilst the attainment of flow in the context of combat may represent the basis of an identity based on courage, it may also serve to undermine it.

Similar phenomena have been observed in other high-performance and role-based professions such as dance and music, which may similarly prime exhilarating perceptual memory, often in contrast to anxiety or fear. An example of this is that of professional dancers who were reported to use states of flow to regulate anxieties born of early trauma histories (Thomson and Jaque, 2012) and the phenomena has also been noted in musicians (Kirchner, 2008). Given the high degrees of sensation (visually and audibly), as well as the emotions involved with successful performance, validation and bonding in these role-based, performance-based professions, there exists a similar potential for over-identification with the role that frames flow, which in turn, relieves anxiety. Again, this may be understood as an increasing externalisation of the self that can diminish subjectivity (or episodic memory) and thereby undermine *personal* identity over time. Under these circumstances, a once strong identity, profoundly framed by a role and held with a degree of omnipotence, may present as complex and fragile when the role is no longer available, or when they (or one of their own) become vulnerable—especially by way of serious wounds, injury, or illnesses. Clearly there are emotional implications during times of change such as rehabilitation, military to civilian transition, or both (Wainwright, Williams, and Turner, 2005).

It is well accepted that traumatic stress has a negative impact on identity, being the source of personal dis-integration (intrusion of affect), horror, helplessness, conditions often associated with dis-order (Van Der Kolk and McFarlane, 1998; McFarlane 2017). What is less talked about is the simultaneous experience of both the fear *and* flow associated with trauma in combat. The latter of these is associated with integration of capacity, agency and competence, but also with the erosion of felt-identity outside the combat role through its impact on episodic memory. It is further suggested that the full impact of role-loss during rehabilitation and transition may not be fully appreciated in the academic literature, especially in relation to

affective disorders. This is despite the fact that some academic work points towards it (Campbell et al., 2016; Nadelson, 1992), and that combat addiction such as that described here is widely discussed in lay internet forums (e.g. see Quora, 2017).

3.8 Implications and recommendations

There are theoretical, social and clinical implications of the above analysis. Theoretically, fear and flow (which in this circumstance are both born of trauma) may be usefully understood as psychosocial counterpoints, that relate to agency and are encoded within the perceptual memory system (see Figure 8 below). If the degree of priming and the extent of emotion attached to these memories are intense, they may intrude upon and fracture episodic memory, or that which is associated with consciousness recall, verbalisation, and the ability to adopt alternate viewpoints (Brewin, 2014).

Fear	Flow
• Dis-integration (intrusion of affect) • Horror • Helplessness	• Integration of capacity • Euphoria • Agency

Figure 8. Opposing psychosocial characteristics of fear and flow

The experiences of fear and flow were central to combat and because a) each has its own impact on felt agency, and b) agency is related to identity and sense of self (American Psychiatric Association, 2013), all these may present as complex in combat veterans, especially when their role (which frames flow and felt confidence) is threatened or lost.

Building on this theoretical implication, social responses to support veterans who are suffering both during and after service may be usefully directed toward supporting their personal identity. This support may include recognition and management of intrusive affect (potentially experienced as fear *or* euphoria of flow) and helping them regain a sense of subjective self through providing a framework to help them develop (or redevelop) a coherent personal narrative.

Supporting veterans in this way may also involve the development of a military-to-civilian healthcare system. In such a system, transitioning personnel would be able to access primary health professionals within their communities, such as counsellors and general practitioners, who understand the complexities of such transition and the impact this may have on a combat veteran's sense of self and health. Such professionals and community support workers (who

would ideally have personal military experience themselves) may be well positioned to both help veterans cohere their identity from an intellectual standpoint, and act as constant transitional objects through which an old and new identity may be negotiated through relationship (Winnicott, 1969).

A policy response may also involve supporting those transitioning from the military to find new and different occupational roles in a way that builds on an identity forged in courage, and yet allows for the laying down of new perceptual and episodic memories that support veterans in a civil context. One such way might be to develop a supported 12-month internship across civil industries and organisations that provide three to four departmental rotations. This internship would ideally foster subjectivity, self-awareness, and help transitioning personnel to learn about a new and meaningful industry by way of language and culture, wherein new employment and educational pathways may be found. This may be usefully understood as a period in which a new self may be practiced. At the same time, employers may choose to learn about the unique perspectives of interns and identify opportunities for unique contribution.

At a clinical level, exploration of trauma-informed approaches that consider the impact of trauma on sense of agency and *personal* identity might be considered for those with complex transition needs. These may include intersubjective psychodynamic approaches (Carr, 2011; Hendin, 2017), existential ones (such narrative or logotherapy) (Erbes et al., 2014; Southwick et al., 2006), or programs that use a combination of these, such as the Skills Training in Affective and Interpersonal Regulation (STAIR) package (Cloitre, Jackson, and Schmidt, 2016; Landes et al., 2013). To supplement these, engagement in community and nature-based approaches such as yoga, sport, and the arts (Ali and Wolfert, 2016; Caddick and Smith, 2014; Johnston et al., 2015) may be considered. These community-based interventions all provide opportunities for the experience of connection and flow, and thereby the laying down of new and less intrusive forms of perceptual memory, in sustainable and low-cost contexts, within a veteran's new community-of-place.

In terms of veterans underutilising health services, these results suggest that focussing on the negative aspects of combat in clinical settings, without accounting for the range of heightened experiences of it, may impede the development of rapport with clients who have served in this capacity. The results also give support to Campbell et al. (2016) who propose that the positive interpretations of combat (including arousal and re-experiencing symptoms) be included in screening tools that may detect dysregulation associated with PTSD and other mental health

conditions. This approach may improve symptom recognition for both combatants and their clinicians, and thereby facilitate early, strength-based mental health interventions.

Given the nature of reflections provided by participants, the question as to whether recollections of horror are incompatible with those of flow must also be raised. This is especially important because perceptual memories (especially those that present as flashbacks) are understood to be vivid and emotional, yet incomplete (Brewin, 2014); and there exists the possibility that the flow associated with trauma may not be mutually exclusive to fear—which may account for delayed accounts of PTSD (McFarlane, 2010a, 2010b). To answer these questions, future exploration of perceptual memory structures as they relate to episodic ones, is required.

3.9 Conclusion

As previously outlined, there is a dearth of evidence that links combat to health behaviours such risk-taking, self-harm, and suicide. This relationship is mediated by affective disorders and PTSD (Maguen et al., 2011), and most research to date that explores psychological and emotional consequences of combat does so using instruments such as scales, but this gives little depth or account of what is actually traumatic to combat veterans. Contrary to what is proposed in most clinical environments (which focus on states of fear, horror, disgust and helplessness) (Van der Kolk et al., 1996), the present nuanced exploration of combat experience demonstrates what combat veterans describe as a far different memory state. The current research demonstrates that for many, combat is largely experienced as positive and brings about a strong sense of agency. At the extreme, some participants came to over-identify with their role and described themselves (and others) as addicted to it. This state can be accounted for by the way in which perceptual memory is laid and primed, and positively impacts sense of agency: a state highly adapted to countering states of fear. While perceptual memory can serve to strengthen autobiographical episodic memory, extremes states of it can also fracture such memory by way of intrusion, which in turn, can undermine identity, making some combat veterans particularly vulnerable to affective disorders during rehabilitation and transition.

These findings and analysis may assist in informing development of a framework for rehabilitation and transition practices, providing indications of the types of interventions that may best serve combat veterans who suffer during times of change. It is suggested that interventions be both psychotherapeutic, by way of managing affect and creating a coherent narrative; and, social in nature—thereby promoting agency, identity and connection in a new context. Finally, this research highlights the fact that combat, for those who have recently

participated in it, is often experienced positively. Unless this is acknowledged, building therapeutic relationships may continue to prove difficult and impact the ways in which society cares for our most courageous and capable members—our veterans.

Chapter 4: The meanings soldiers attach to health and their impacts on primary healthcare utilisation and avoidance in a high-risk combat unit

4.1 Preamble

The themes documented in Chapter 3 demonstrated that how participants forged affective bonds with their task and team served to increase collective identity, but also undermined a personal sense of it. The combination of increased collective identity on one hand, and diminished identity on the other, resulted in participants developing a degree of dependence on their role.

This chapter documents the degree to which identity developed in and through combat, influenced the participants' understandings of health, and the ways these impacted health behaviours such as help-seeking. To elucidate, health was understood as *functional fitness*, characterised by a state of personal agency (linked to role performance); and, interpersonal trust (linked to their team). Both these ideas of health were construed as barriers to help-seeking, as participants interfaced with garrison health services.

4.2 Statement of authorship

Title of paper: The meaning soldiers attach to health and its impacts on primary healthcare utilisation and avoidance in a high-risk combat unit

Publication status: Not submitted

Principal author

Name of principal author (candidate): Paula Dabovich

Contribution to the paper: Conducted literature review, devised scope, aim and interview questions. Planned and conducted interviews, transcribed, coded and analysed data. Composed and wrote article.

Overall percentage: 85%

Certification: This article documents original research conducted by Paula Dabovich as a part of her higher degree by research candidature. It is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. Paula Dabovich is the primary author of the paper

Signature: Date:

Co-author contributions

By signing the Statement of Authorship, each author certifies that:

iv. the candidate's stated contribution to the publication is accurate (as detailed above);

v. permission is granted for the candidate to include the publication in the thesis; and

vi. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of co-author: Associate Professor Jaklin Eliott

Contribution to the paper: General oversight and monitoring of research design and conduct including question design, data collection and analysis. Provided structural feedback and editorial guidance on manuscript.

Signature: Date:

Name of co-author: Professor Alexander McFarlane

Contribution to the paper: General oversight of research and provision of strategic guidance. Provided feedback on manuscript.

Signature: Date: 20/04/2018

4.3 Abstract

Through analysis of in-depth interviews with 13 rehabilitating members of an Australian Army high-risk combat unit who talk about their health, we examine the meaning these soldiers attach to health and healthcare avoidance. Whilst supporting previous findings that engagement with health services is perceived to negatively impact career advancement and prospects for deployment, our results suggest these issues were marginal to perceptions of losing personal agency when engaging with the healthcare system, and subsequent mistrust of it. These factors related to physical and psychological concerns, and resulted in avoidant health behaviours, including preference for self-management. We conclude by arguing that issues of mistrust underscore healthcare avoidance in military high-risk units, with detrimental outcomes for both individuals and the organisation. We recommend the development and implementation of culturally sensitive primary healthcare principles to garrison health services which emphasise personal agency and interpersonal trust during clinical interactions.

4.4 Introduction

Defence personnel often undertake roles which are physically, psychologically, and socially demanding, both domestically and internationally. The Australian Government is committed to achieving the best health outcomes for Defence personnel and veterans with an annual expenditure of over $AUD52 million in mental health care and research (Prime Minister of Australia, 2016). This commitment is further evidenced by the 2016 Senate Inquiry which sought to contextualise Australia's elevated rate of veteran suicide within broader administrative frameworks (Australian Institute of Health and Welfare, 2017; Parliament of Australia, 2017).

Despite this commitment, many serving members continue to experience higher rates of mental health disorders compared to civilians (McFarlane et al., 2011). In addition, many are discharged from service on medical grounds (Centre for Suicide Prevention, 2014; Ministry of Defence, 2015), after which they are considered at higher risk of chronic and complex health conditions. These conditions include post-traumatic stress disorder (PTSD), alcohol use disorders, and chronic inflammatory responses (Capone et al., 2013; Foa et al., 2009; Lang et al., 2012; Pols and Oak, 2007).

It is widely accepted that many of these conditions may be prevented or reduced in severity by early primary healthcare interventions (Koes, Van Tulder, and Thomas, 2006; Valtonen et al., 2015), yet research suggests that military and ex-military personnel avoid or underutilise

the services offered to them (Currier, Holland, and Allen, 2012; Hoge et al., 2004; Jakupcak et al., 2013; Pols and Oak, 2007; Tsan et al., 2012; Vogt, 2011). Various reasons for this avoidant behaviour have been suggested, including personal factors such as fear of stigma (Ben-Zeev et al., 2012; Blais and Renshaw, 2013; Blais, Renshaw, and Jakupcak, 2014; Gould et al., 2010; Held and Owens, 2013; Kim et al., 2011; Mittal et al., 2013), fear of losing professional and deployment opportunities (McFarlane et al., 2011), as well as unhelpful/specific personal beliefs and attitudes towards illness and care (Kim et al., 2011; Vogt, Fox, and Di Leone, 2014). There are, however, limitations in the current literature around this phenomenon. First, investigation into healthcare avoidance has almost exclusively considered mental health conditions and mental health services, with relatively little examination of healthcare utilisation for physical or social concerns. Accordingly, most scholarly debate focuses on issues such as the individual's fear of mental health-related stigma, rather than viewing healthcare avoidance more broadly. Second, research has been overwhelmingly quantitative (c.f. Sayer et al. (2009), utilising questionnaires and quantitative surveys. Past research has measured the attitudes and beliefs of military personnel, but has not articulated what these might mean in the context of rehabilitation, and how such meanings may prompt specific actions or behaviours. In their focus on the individual, such research has also overlooked interpersonal interactions and relationships with health professionals, and healthcare systems. Finally, through focusing on 'lack of health,' howsoever manifested, the ways in which military personnel experience 'health' have not yet been established in the literature. Such knowledge is essential to understand military personnel and their needs, enable effective engagement to facilitate culturally relevant structures and programs to improve health and wellbeing (Hunt, 2001; Swiggum, 2001; World Health Organization, 1978), and thereby improve capability outcomes.

4.5 Participants and method

The University of Adelaide and the Australian Defence Human Research Ethics Committees approved this qualitative study. A qualitative, contextual approach, positioned between critical realism and social constructivism (Braun and Clarke, 2006; Willig, 1999), was employed to account for the necessity of military structure, the social responses it espouses and how these shape the experiences of participants. Thematic techniques were used to analyse the data (Liamputtong, 2013).

Following ineffective attempts to recruit participants using unit-based health clinicians, a senior soldier initiated a snowball method amongst his peers. Methodologically (and

illustrative of the issues herein discussed), this was crucial due to the tight-knit cohort, together with their general reluctance to engage with health professionals. This method enabled effective recruitment to data saturation (Fusch and Lawrence, 2015) which occurred at 13 participants. All participants were male, ranged in age from 32-39, and were undergoing rehabilitation for physical combat wounds (n=8), physical injuries (n=3), as well as psychological injury and illness (n=2). Each took part in two in-depth, semi-structured, interviews with the first author, each lasting approximately two hours. Themes were identified in the first series of interviews and reviewed by the second author. The second series of interviews included discussion of preliminary analyses and themes, thus providing further insight into the themes and participant validation to check accuracy (Bygstad and Munkvold, 2007).

Interview questions prompted discussion about biopsychosocial elements of health and well-being over time, with explicit focus on participant choices and current situation. Interviews progressed to employ a timeline elicitation technique (Sheridan, Chamberlain, and Dupuis, 2011) where the participant and researcher worked with colour to develop their perspectives of motivations and health, focus discussion, and re-present their complex experiences. As an example, blue was used to mark how participants saw their physical health on the timeline, and other colours to denote social and psychological aspects of self. Participants marked the timeline as many times as required to represent themselves in health, poor health, and during change, with further prompt questions asked, e.g. “what does that mean to you?”, “can you tell me more about that?” and “what was going on around then?”. Figure 9 represents a typical timeline, depicting five stages of their adult life: civilian, conventional soldier, high-risk combat soldier, during rehabilitation, and the future.

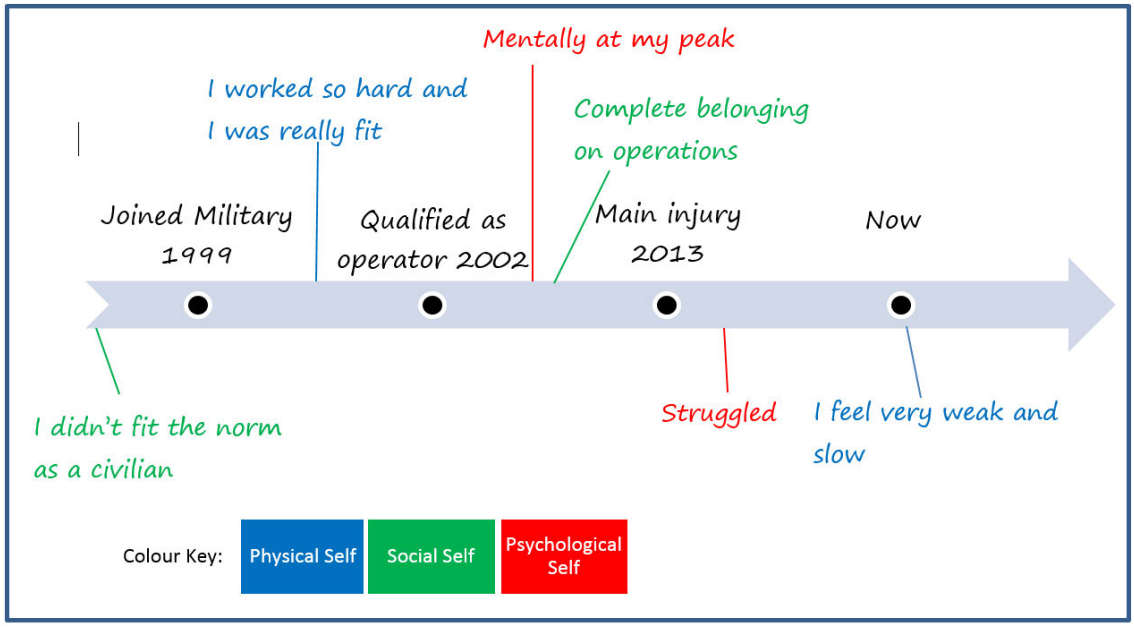


Figure 9. Typical timeline representing participants' perception of self over time

Most interviews were conducted in a secluded office within a community facility, located on base outside the participants' unit; five participants preferred to be interviewed in or near their homes. During the second round of data collection, two members (one on operational deployment, the other on a training exercise) participated via telephone. All interviews were audio-recorded and transcribed verbatim with identifying information altered to protect participant identity. Non-lexical speech such as "um" "err" and "ah" was also omitted at the transcription stage (Stiles, 1992). The text was entered into NVivo (QSR International Pty Ltd, 2012) to aid analysis.

For the purpose of this analysis, preliminary coding focused on participants' explicit responses to questions around what health and poor health *meant* to them in the physical, psychological, and social domains. The codes thus established were compared to identify similarities and differences in what constituted good (and poor) health across the biopsychosocial domains (Engel, 1977).

The second stage of analysis involved collating speech regarding the healthcare system and clinical interactions to focus on what these meant to participants, their own behaviours in relation to the system, as well as the health behaviours they observed in others within their regiment. Quotes used in this report are illustrative of the dominant themes, unless otherwise stated.

4.6 Results and analysis

Participants talked about health in terms of functional fitness. This was experienced personally as having a sense of agency, and collectively, through mutual trust. Although these themes were central to speech around health, participants described them as lacking in most primary healthcare interactions, which in-turn, influenced their healthcare and help-seeking behaviours.

4.6.1 The experience of health: functional fitness

Most participants understood health as being fit-for-role, or more succinctly, as functional fitness: "Healthy for me is just functionality" and "If you can do your job properly, everything [else] is irrelevant." For most, successful performance of their role related to an immense sense of fulfilment and wellbeing, expressed thus:

> [when] we are away on a deployment we feel really important, … we are doing a job that we are trained to do. Emotions are high. Tensions are high. Everything is at a pinnacle. You're just really *en pointe* [at the leading edge]. ou are always feeling better when you doing your job for real. *(4.1)*

Functional fitness was primarily expressed in term of personal agency and interpersonal trust.

4.6.2 Personal agency

Participants experienced a sense of personal agency when they had the confidence and ability to do three things: perform their role, adapt to challenges, and grow. Paradoxically, the role of participants, including the inevitability of injury, might be seen to limit their agency, but they described it as a manifestation of their freedom of choice:

> [Health is] being able to do anything you want really … fit, strong. No injuries. You don't live without injuries, so I suppose it would be being able to cope with injuries, more so. *(4.2)*

The ability to cope or adapt to injury, and the confidence related to doing so, is here described in terms of physical health (fit, strong), however, similar themes featured in speech about mental health.

> [Good mental health is about] feeling confident in the decisions you're making. Being happy, and [having] the ability to mentally deal with problems without freaking-out. *(4.3)*
>
> [Good mental health is] to know you are going to have good times and bad times and to be able to go through it. *(4.4)*

A sense of agency appeared to relate to having the confidence to adapt physically and psychologically to challenges. In addition, personal agency was also understood as a foundation for (and consequence of) both individual (i.e. personal) and collective growth,

partly through successful role performance and the ability to adapt to challenges. Most participants spoke of the collective impact of their individual efforts, but this was invariably associated with talk about how belonging to the collective positively influenced the individual:

> So everyone had a purpose. Everyone. It was clearly understood, it was clearly defined. Everyone worked towards that. Everyone worked together. We still had the occasional hiccup on the way, but we achieved a lot … we took it a little bit further and regained trust, but also developed capabilities. So we would be leaders in the unit for doing that. *(4.5)*
>
> It makes you happy to belong to something … If you belong to something, you wish to improve it, and should always be seeking to improve it. *(4.6)*
>
> It is really good being a part of a professional, slick, and fast-moving group. It breeds a lot of confidence. *(4.7)*

Accordingly, personal agency was experienced as an inner-assuredness: "a position of strength and total self-confidence" and as being "secure in your own abilities and attributes." Ultimately, such talk suggests a positive and recursive relationship between personal agency and collective capability (see Figure 10).

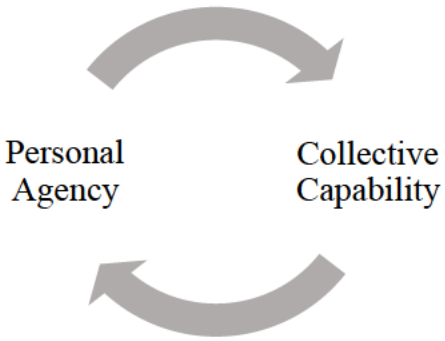


Figure 10. The recursive relationship between participants' experience of personal agency and collective capability

4.6.3 Interpersonal trust

Participants described health in terms of functional fitness requiring both personal agency and interpersonal trust. In the above, self-confidence may also be construed as 'self-trust,' being the extent to which participants trust themselves to perform, adapt, and grow. Trust was also described as a necessary interpersonal component of the team, with individuals required to both trust others, and to be trust-worthy.

Given the dangerous and team-based characteristics of high-risk combat operations, mutual trust within the team is logically related to personal and collective survival. Knowing that others were to be trusted fostered a sense of security, stability, and confidence in participants, even when operating within unstable environments.

> Something about being in a team … that is operating at a high level that is reliant on each other in a positive sense. Reliant [in] that I know I can count on somebody else to get me out of trouble. So, there is a confidence [that] comes with that. *(4.8)*
>
> It felt great, knowing you have someone you can trust, who's got your back. *(4.9)*

Further to trust in self and others, participants talked about the impact of others having trust in them, as engendering a sense of maturity and agency. This was evident in talk about lateral peer relationships and hierarchical command relationships. Some participants specifically spoke about the positive impact of having the confidence of those higher in the chain of command: "dudes here are treated like adults, and we are entrusted with real [significant] jobs" and:

> … achieving our missions or at least our role within the missions, it made us more cohesive because we could trust each other to do the job without being told twice and things like that, but also, for the hierarchy and the guys higher than us, know that, and we know that they know. They have faith in us, to send us out and do what we got to do. *(4.10)*

This was also the experience of participants with subordinates:

> I was climbing up the ladder within the unit … it was good. I was promoted to team commander. [There] were a couple of blokes under me who were looking to me for answers, and it makes you take that next step. The more responsibility the harder you work, I suppose. *(4.11)*

It appeared that the more participants were entrusted, the harder they worked to honour that trust. Thus, trust emerged as an organisationally powerful condition of mutuality achieved through mission success. It was also described as a consequence of shared adversity and survival. One participant explained:

> … experiencing misfortunes together, operationally … It brings it [the team] tighter … it adds to your level of trust. That you can depend on each other, not matter what. You give more faith to each other. *(4.12)*
>
> You would do anything. You just know you would give up your life for your guys and they would do the same for you … You just know. *(4.13)*

Such talk suggests a recursive relationship between interpersonal trust and collective capability (see Figure 11).

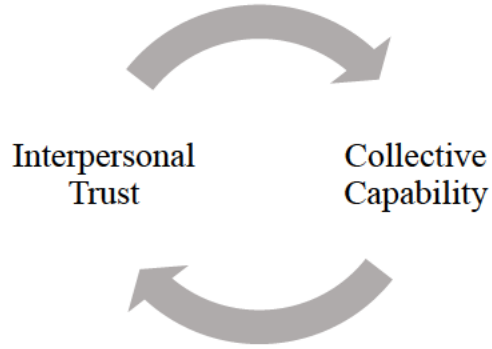


Figure 11. The recursive relationship between participants' experience of interpersonal trust and collective capability

To summarise, functional fitness, as a foundation for participants' health, was described in terms of personal agency and interpersonal trust. These positively impacted collective capability and the emotional health of participants, to which we now turn.

4.6.4 Functional fitness and emotional health

Functional fitness, being essential to capability and thus survival, positively affected the emotional health of participants through increasing feelings of happiness, comfort, and stability. These feelings were mediated through the sense of identity and belonging which came with being a *good-fit* for the task or team:

> I was extremely comfortable in my job. I was very comfortable that I could do everything that was required of me. Fitness wise and skill wise … [it's about being] secure in your own abilities and attributes. *(4.14)*
>
> To belong is probably one of the most important feelings out of anything … it makes you happy to belong to something. Contentment. *(4.15)*

Despite the positive emotional impact of belonging or fitting-in, it was neither presumed nor taken for granted by participants. Instead, it was a relatively conditional state, constantly interrupted by change. In and upon each changing circumstance, participants reported the requirement to re-establish and re-prove themselves, for example:

> This job is an everyday renewable contract. Just because you have proved yourself now, on this course, or this year, or [in] this platoon or team, or trip, or exercise, or operation, or whatever; it doesn't mean s**t. You need to prove your worth every day. *(4.16)*

Proving their fitness was essential to re-gain trust, along with acceptance and respect: "once you have proven yourself, you become accepted" and upon which "you get a bit more respect

from the guys." This is indicative of the value that participants placed on functional fitness and its relationship to emotional health.

4.6.5 The experience of the military primary healthcare system

Although personal agency and interpersonal trust were central to participants' experience of health, they were described as absent in most primary care interactions. These were instead characterised by a *lack* of trust, which rested upon three factors: First, participants did not know where clinical alliances lay; second, disclosure of vulnerability was associated with the loss of personal agency; and third, there were difficulties in identifying with, and thus relating to, healthcare professionals.

4.6.6 Mistrust of healthcare allegiances

Participants spoke about their confusion regarding the role of clinicians. Some talked of this directly and others more generally:

> I wasn't sure where her [the psychologist's] alliances laid. If they were more with me or more with the unit [the unit being the broader parental organisation which provides military capability]. *(4.17)*
>
> There is certainly a lack of trust with some of the medical staff. *(4.18)*
>
> They [medical and psychological staff] are not a part of the fold. They are not a part of the high-risk cadre where we trust each other and we work for each other. *(4.19)*

One participant talked about the experience of a peer, which undermined his personal confidence psychological services:

> I know of a situation, of a guy here. He spoke to the psych [psychologist] in *confidence* and the psych went and told various other people because he was the only person who knew that information. So why would you go and speak to the psychs then? Because it's not *in confidence*. And I know with self-harm, stuff has got to be declared [to command] but this had nothing to do with it. *(4.20)*
>
> Italics added

These participants' accounts suggest that although clinicians and participants here worked for the same unit in the same army, and mutually aimed to serve the same cause, a diminished sense of trust served to fracture unity. As interpersonal trust was constituted as central to capability, the impact of this fracture may have far-reaching consequences for both the individual and the collective.

4.6.7 Loss of agency

In addition to, and perhaps because of, participants' uncertainty about clinical alliances, they associated engagement with primary healthcare services with a loss of personal agency:

> As soon as you cross that line and you say 'can you check this out? I might need to get it fixed' then the MEC [Medical Employment Category] downgrade comes and then you lose total control over your ability to do your job. … The fact of presenting to the RAP [Regimental Aid Post] or any health support side of the Army, is potentially taking control of everything about your work life away from you. It is quite daunting for someone to present with anything. *(4.21)*

Correspondingly, primary healthcare services and the associated Medical Employment Categorisation system (the system which categorises personnel in terms of ability) were perceived as overly restrictive:

> Because guys want to continue doing their job and if they know that they can, you know, with a minor injury, that they can overcome or adapt, they certainly want to continue on. They don't want to be blocked by some red tape or something broad and bureaucratic. … Instead of being a case by case thing, it can very easily block people out. *(4.22)*

Participants' experience of primary healthcare as depersonalised, bureaucratic, and somewhat disempowering, ultimately had a negative impact on their sense of agency, precisely at a time of heightened vulnerability. This emerged as in direct contrast to their experience of health as functional fitness, characterised by personal agency and interpersonal trust.

4.6.8 Issues of (non) identification

A clinician's ability to identify with participants was presented as crucial to the development of trust and thereby, a successful therapeutic alliance. This was evidenced through speech about helpful and unhelpful clinical interactions. Of a helpful interaction, one participant reflected on his ability to talk openly with a counsellor in the United States. This was understood to be consequential on a shared lived experience of active service.

> The counsellor there [in the US] was an ex-marine, and I was happy to talk about things. He just gets it. You don't need to explain things. It's not like you are p*ssing in each other's pockets, it's weird. The way you think is different. Through all of your experiences and your training, it moulds the way you think. And when you are with someone who thinks the same way, you notice it. It's a good thing. You are already on the same wavelength. It is totally, totally like that. *(4.23)*

The term "p*ssing in each other's pockets" used here is an Australian colloquialism for insincerity and may be indicative of the lack of shared experiences that precluded connection and disclosure in other clinical relationships. Examples of this were abundant in the data, with 'others' (e.g. therapists, civilian doctors, clinicians) all understood to have 'no idea' of participants' past or current circumstances.

> You are talking to therapists that have *no* idea. At all. Absolute. … A total disconnect. I mean like, you try to explain something … I remember, not so

> much my first two Afghanistan trips, there was a lot of war fighting in the first two trips, but on the third one, we lost three guys and 11 were wounded. Jack was a really, really close mate of mine… Seeing a dead mate, that will change you forever, you know? And so you try to convey that to a psych who probably has no real experience of death. *(4.24)*

> The civilian doctors, I know they mean well, but they just have no idea about what we need, or what we do, and where we want to get to. *(4.25)*

> You just sort of give-up on trying to explain it to them [clinicians]. You don't even bother trying to explain it to them. If they don't grasp it, you just don't think they are ever going to. *(4.26)*

Here, the language used (e.g. 'a total disconnect,' 'no idea,' you don't even bother') conveys the challenge, even implausibility of participants entering into a therapeutic relationship with others, however well-meaning, who lacked a shared military experience. It is possible to see here how the extra-ordinary and shared experiences of participants works to establish and consolidate their sense of shared agency, but simultaneously creates a barrier to identification with (and thus disclosure to) many people, including clinicians.

4.6.9 Avoidant behaviours and their consequences

As noted above, the relationship between participants and the health system was characterised by mistrust. This inhibited personal disclosure, which in turn, precluded effective therapeutic alliances between participants and their clinicians. Accordingly, participants avoided unit healthcare services and engaged in active self-management of both common minor injuries and serious health concerns: "This unit here, they hide big stuff. They never go to the doctor; they avoid them." Self-management strategies included treating conditions themselves (including self-medication), obtaining non-military healthcare, and pushing against past medical restrictions placed on them.

> The PT [physical training] session done two weeks ago … [A] guy tore his ITB [iliotibial band]. Another guy twisted his ankle, another guy did his hip flexor. None of them went to the RAP [Regimental Aid Post] because as soon as you say you are injured in any way, it's not like "ok, no worries, rest up and tell me when you are good to go,"… It's like "ok, you are injured, and you are off. You are benched." So … they're like "f**k that, I won't be able to do any of this s**t!" *(4.27)*

Participants' maintenance and demonstration of functional fitness, such that they were always ready to serve, was consistently presented as a powerful motivation for concealing both psychological and physiological concerns:

> We hide what we have wrong with us, especially if there is an opportunity of a gig coming up. So you don't want to miss out on that. If the doc doesn't like it, and down-grades you, you are up s**t creek. … Most of us would be dead and still be trying to crawl onto a gig. *(4.28)*

> Guys won't go and see a psych. … Guys will only see a psych if they know 'yeah, I'm done'. Literally. If they still want to be in a team, or go overseas or whatever, they won't speak to a psych. They won't. Because soon as they start speaking to a psych, it's like, "yeah, I'm going down that path now." So it is either one or the other. *(4.29)*

These excerpts suggest that participants minimised the significance of their own injuries to avoid the risk of being removed from all that they value. It also draws attention to the all-or-nothing constructs featured in participants' speech, evidenced here by the term "it is either one or the other." In the context of health, care providers were positioned as gatekeepers who had the potential to "block people out", even as motivated to do so.

> The senior medical officers, they're looking to find ways of removing that person … to the point where you just don't want to say anything. *(4.30)*

The perceived lack of an intermediate space within a system that would "chop you open or send you to physio—not anything in between," seemed to mandate and shape such extreme responses. Accordingly, avoidance of military healthcare services was often coupled with self-management or the utilisation of non-military care, thus allowing for the safe exploration or treatment of health issues without risk to functional fitness. This was also associated with a minimisation of the significance of their symptoms:

> … so why would I go and give up the only thing that is my livelihood? … I could tell you 10, 15, 20, 30 guys, who get through Monday to Friday, get on the piss Saturday, Sunday, just to get back Monday to Friday, so they can stay in the job, so they can redeploy so they can feel relevant. We know that we are a government strategic capability … so why would I want to lose my pay and my relevance all because I have a few nightmares? I wouldn't. And you will find that more and more of the guys are doing that. *(4.31)*

> You want to go over with your mates. … It is more like 'I can either do it, or I don't' you know what I mean? People will put up with things or they will go and seek medical advice outside of Defence, and try to get something done… They might pay $1000 to get an MRI [privately] but they will be making money on the deployment. *(4.32)*

Under these circumstances, some participants were able to conceal and manage minor issues. Indeed, to do so was construed as in keeping with how they performed every day, in that "we are always pushing ourselves harder than the restrictions being placed on us." For others, however, the perceived need to conceal any condition and thus to avoid seeking help, saw relatively minor issues develop into serious ones.

> So guys will carry it [injury or illness] until it catastrophically fails, and are forced to do something about it …, it is the same across the board. *(4.33)*

For most, turning to military care was a last option. Somewhat paradoxically, if soldiers only seek care when they are unable to continue to serve, this seems likely to reinforce perceptions

that to see a healthcare provider is to risk removal from active service. With these perceptions in place, participants reported behaving in a way which was consistent with their idea of health: by resisting engagement with the health system as well as any previous restrictions placed on them, they maintained their sense of agency, belonging, and thereby, identity. Sometimes this positioned soldiers in direct opposition to the medical profession:

> You get that defiant attitude against the medical thing "they told me I couldn't do it, so screw you, I'm going to do this." *(4.34)*

However, what informed participants' decisions to seek treatment through the military, and thereby risk career and deployment opportunities, was not just the strong motivation to return to functional fitness, to be relevant and to serve, but also an awareness of the impact that their reduced capacities might have on others:

> [There is] that motivation of the prospect of failure, always nipping at your heels. Or being a liability, nipping at your heels, and that's what gets those guys that do make that choice, or that identification, 'hang on a second, even though I'm good-to-go on paper, I am a liability. I am not an asset to this team, or in some way, the team has to accommodate my shortcoming because of my injury, or whatever it is' and that's when they go 'wow, it's time for me to go' sort of thing. *(4.35)*

Such speech indicates that participants were confident in recognising when they and their cohort could no longer perform their role, rather than relying on the Medical Employment Category system to mediate this shift.

4.7 Discussion

This research offers insight into previous findings which suggest that military personnel avoid or underutilise the healthcare offered to them due to stigma and perceived loss of career and development opportunities (Currier et al., 2012; Hoge et al., 2004; Jakupcak et al., 2013; McFarlane et al., 2011; Pols and Oak, 2007; Tsan et al., 2012; Vogt, 2011). Findings indicate that issues of personal agency and interpersonal trust underpin this behaviour, being both central to participants' experience and understanding of health, yet perceived to be lacking in primary clinical interactions.

Findings also identified a positive and recursive relationship between themes of health and organisational capability. Personal agency was understood as a foundation for (and consequence of) both individual (i.e. personal) and collective role performance, and adaptation to challenges and growth. Accordingly, interpersonal trust, achieved through both success and adversity, contributed to an organisationally powerful condition of mutuality (see

Figure 12). To that end, participants spoke about how they personally influenced the collective and how the collective influenced them.

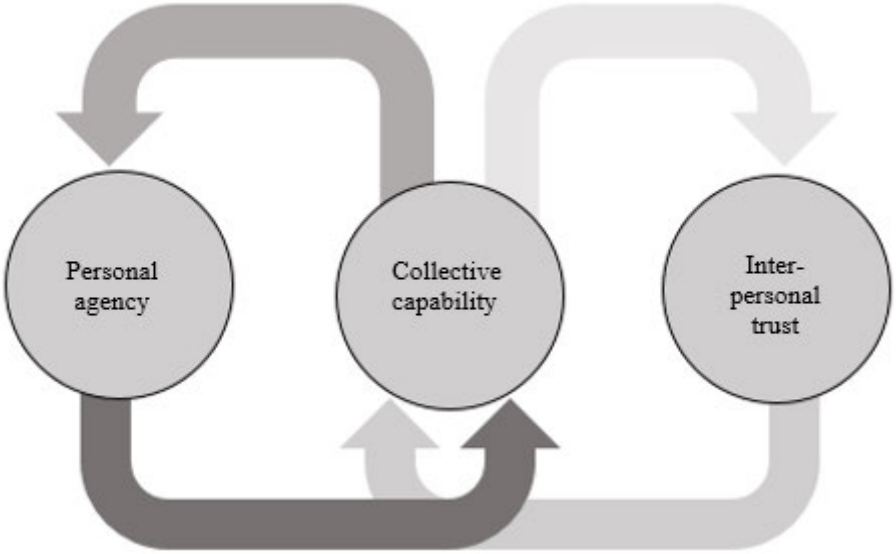


Figure 12. The recursive relationship between participants' experience of personal agency, interpersonal trust, and collective capability

Personal agency and interpersonal trust at both the individual and the collective level ensured personal survival and mission success in this population. However, there may be other reasons contributing to the emergence of these factors as key themes in participants' talk about health. First, personal agency and interpersonal trust are widely accepted as foundational to identity development (Erikson, 1956, 1966). Reflective of this, participants' identity came to be firmly located in their functional fit-ness and their capacity to serve with their comrades. This had a positive influence on their emotional health and wellbeing. Second, both personal agency and interpersonal trust are essential for successful adaptation to trauma, and emerged as an inherent feature of the participants' work (Fallot and Harris, 2009; Garland, 2002; Kezelman and Stavropoulos, 2012; Lifton, 1993; Van der Kolk, 2014). Indeed, disruptions to personal agency and interpersonal trust, either during developmental periods or as a consequence of trauma, are associated with a range of mental health conditions (American Psychiatric Association, 2013), which may in part, account for the elevated prevalence of mental health conditions in military and veteran populations than civilians. As previously mentioned, serving personnel experience affective disorders and suicidal ideation at higher rates (McFarlane et al., 2011) and ex-serving personnel are at greater risk of suicide (Australian Institute of Health and Welfare, 2017).

Although personal agency and interpersonal trust underscore health and capability in this population, developmental psychologists suggest that these features are born from the quality of care and environmental facilitation during times of psychological vulnerability, such as the first three years of life (Mahler, 1974) and again adolescence (Bowlby, 1978; Kroger, 1996; Marvin et al., 2002; Winnicott, 1965). Vulnerability similar to that experienced in childhood may also present after severe injury or illness, at which time, normally independent individuals become dependent on primary objects (or others) (Balint, 1979). Some have argued that a return to primary dependence may represent "new beginnings," or malignancy (Balint, 1979, p. 132), and the facilitating or care environment may go some way in shaping these outcomes (Winnicott, 1965). The latter trajectory of malignancy provide some explanation for why those who experience traumatic injury are at increased risk of both affective disorders (Bryant et al., 2010), suicidal ideation (Bryant et al., 2016), and why those discharged from the military on medical grounds have an elevated risk of suicide (Australian Institute of Health and Welfare, 2017).

When people ask for help, whether it be for physical care, psychological assistance, or social support, they disclose potential vulnerabilities or dependency needs. Results indicate such disclosure in a military clinical context is potentially problematic. Unlike civilian health professionals, who are guided by bioethical principals which afford primacy to the individual, military clinicians must sometimes forego individual primacy and act in favour of the organisation (Dobmeyer, 2013; Johnson, Grasso, and Maslowski, 2010; Johnson, 2008; Rochon, 2015). Within the literature, this duality of interests (i.e., the individual soldier vs the organisation) has been explored conceptually (Gross, 2013; London et al., 2006; Rochon, 2015), interpreted through clinical scenarios and case studies (Dobmeyer, 2013; Johnson et al., 2010), and empirically researched (Gordon, 2014). In these studies, duality is discussed as problematic for clinicians, contributing to a felt tension as they balance individual needs with the needs of the organisation; however, any potential impact on the health and health behaviours of military personnel has been relatively unexplored. This omission is significant, especially in light of the high rates of healthcare avoidance in the military, and the serious and chronic health conditions veterans often experience after service.

Within this study, participants indicated that at times of potential vulnerability and dependence, they neither trusted the primary military health system, nor were they confident that their sense of agency would be upheld, despite these being vital to functional fitness, identity, and adaptation to trauma. For this reason, it is essential that military personnel, who

adopt some of the most physical, psychological, and socially demanding societal roles, are able to *safely* explore and attend to their healthcare needs in a supportive environment.

One possible avenue to increase healthcare utilisation within the military is to incorporate psychologically-framed, primary healthcare principles into garrison health services, thus promoting local ownership and integrating local definitions of health (World Health Organisation, 2008; World Health Organisation, 1978). For example, within this study, participants broadly understood health in terms of functional fitness or role performance. Accordingly, a culturally appropriate way to introduce primary care services to a garrison environment might be to borrow language and delivery concepts from the field of human performance. The language used in this field evokes a sense of growth and ability with words such as "enhancing," "development," "reaching human goals," and "improvement" (Roco and Bainbridge, 2003, p.1) being typical and in alignment with the soldiers' experience of health and military intent. Such an approach may also provide a platform for identity continuity in those who are no longer able to perform the roles for which they have trained and to which they have committed. This is especially important for veterans who often struggle with identity issues in a post-heroic society (Beaumont, 2014; Brewin, Garnett, and Andrews, 2011; Brunger, Serrato, and Ogden, 2013; Feinstein, 2013), and for which separation may represent similar challenges to those experienced in adolescence, albeit in a battle-scarred mind and body (Wilkins, 2010).

Participants also reported marked difficulties in developing therapeutic relationships with clinicians who did not share military or traumatic understanding. This lack of identification contributed to healthcare avoidance in the military and may contribute to veteran healthcare avoidance in the civil community. This highlights the need to create and coordinate clinical care to ensure that service personnel and veterans can access informed and trusted support which account for their unique experiences. Indeed, there is a growing body of evidence which suggests clinical relationships based on trust improve health outcomes in both civilian (Fiscella et al., 2004; Hall et al., 2001; Safran et al., 1998) and military populations (Lv et al., 2016). Given the national presence of the military, this type of coordinated care should exist at primary, secondary, and tertiary levels, and be networked locally and nationally. This will ensure transitioning personnel have easy access to informed and culturally relevant care, and where necessary, a degree of continuity in their existing care.

4.8 Limitations

This study was limited to the experience of high-risk combat soldiers in the Australian Army and as such, offers a unique perspective of health and healthcare avoidance in the military. A broader understanding of these issues may be achieved by conducting similar research with other military units, including those of the Navy and Airforce. Such research has the potential to inform national policy (through the identification of sameness) as well as local practice and service delivery (through identifying areas of difference). Given the link between health and capability identified in this research, such insight may also contribute to the understanding and execution of military leadership and personnel management.

4.9 Conclusion

Military personnel who operate in high-risk combat units willingly adopt roles that demand extraordinary physical, psychological, and social performance, both domestically and on the world stage. Despite this and despite the value placed on their role by both themselves and others, participants in this study were reluctant to seek military healthcare support for physical and psychological concerns. Such avoidance sometimes resulted in serious breakdown. This research examined the behaviour from a relational perspective, and found that issues of personal agency and interpersonal trust were central to the experience of health and collective capability, yet were lacking in clinical interactions. The current research indicates this disjuncture is detrimental to both individuals and the military and suggest additional strategies to encourage better healthcare provision, building upon soldiers' perceptions of health, their articulation of need, and building upon what they value. To assist in meeting the needs of the individual, the collective, and ultimately the nation they serve, we suggest the incorporation of psychologically-framed primary healthcare within garrison services, emphasising personal agency and interpersonal trust. Such an approach has the potential to both support military capability and the needs of individuals, as they mutually aim and support one another in the defence of our nation and its interests.

Chapter 5. Loss and limbo: high-risk combat soldiers' experience of themselves during rehabilitation in the Australian Army

5.1 Preamble

Chapters three and four described the paradoxical nature of participants' identity and agency: strong and powerful in the context of their role, but potentially fragile outside it. This phenomenon was observed to underpin avoidance of garrison healthcare, and some participants avoided healthcare altogether. To an extent, avoiding healthcare was a means to defend identity and agency. Nonetheless, regardless of how successful participants were in avoiding healthcare (and in some cases precisely because they did so), all had been removed from their primary group as a consequence of the overwhelming nature of their wounds, injuries, or illnesses.

In this chapter, the consequences of developing a strong, yet highly contextual identity is documented. Participants were faced with experiences of becoming precisely all they had previously prided themselves in not being: vulnerable, limited and flawed—the very antithesis of their former self. This position evoked feelings of loss and states of limbo and was associated with varying degrees of both helplessness and anger. At the extreme, a lost sense of identity and agency prompted self-destructive behaviours and ideations.

5.2 Statement of authorship

Title of paper: Loss and Limbo: high-risk combat soldiers' experience of themselves during rehabilitation in the Australian Army

Publication status: Not submitted

Principal author

Name of principal author (candidate): Paula Dabovich

Contribution to the paper: Conducted literature review, devised scope, aim and interview questions. Planned and conducted interviews, transcribed, coded and analysed data. Composed and wrote article.

Overall percentage: 85%

Certification: This article documents original research conducted by Paula Dabovich as a part of her higher degree by research candidature. It is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. Paula Dabovich is the primary author of the paper.

Signature: Date:

Co-author contributions

By signing the Statement of Authorship, each author certifies that:

5 the candidate's stated contribution to the publication in accurate (as detailed above);

6 permission is granted for the candidate to include the publication in the thesis; and

7 the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of co-author: Associate Professor Jaklin Eliott

Contribution to the paper: General oversight and monitoring of research design and conduct including question design, data collection and analysis. Provided structural feedback and editorial guidance on manuscript.

Signature: Date:

Name of co-author: Professor Alexander McFarlane

Contribution to the paper: General oversight of research and provision of strategic guidance. Provided feedback on manuscript.

Signature: Date: 20/04/2018

5.3 Abstract

Background: Self, as a locus of identity and agency, is relevant to behaviour in all domains of military service. A veteran's sense of self will directly impact how they experience and relate to others, including families, unit personnel, and health care providers; yet it is little accounted for in understanding veterans' health and health behaviours during times of change, such as rehabilitation and transition. **Aim**: The aim of this paper is to report how the identity and agency of serving Australian high-risk combat personnel is impacted by serious wounding, injury, and illness during rehabilitation; and the extent to which this relates to health and behaviours. **Method**: Thirteen Australian high-risk combat soldiers, who were rehabilitating from serious wounding, injury, and illness, each took part in two semi-structured recorded interviews over nine months. Interviews lasted an average of two hours and yielded approximately 50 hours of primary interview data. Analysis employed a thematic approach, positioned between critical realism and a qualitative social constructionist paradigm. **Results**: Participants experienced a cascade of self-loss followed by a state of limbo. The experience of loss and limbo are discussed, along with participants' inner states of anger, frustration, depression and anxiety, as well as self-discomfort and dislike. At the extreme, some participants engaged in self-destructive behaviours and suicidal ideation. **Conclusion**: Understanding military personnel's experience of themselves during rehabilitation is essential to facilitate culturally sensitive health, rehabilitation and transition practices. Findings of this research will assist in creating dialogue around the perception of self during rehabilitation, thereby contextualising and normalising some of the more difficult experiences. This knowledge will be useful to medical, nursing, and allied health professionals, as well as lay carers who work with veterans during times of significant change, such as rehabilitation and transition.

5.4 Introduction

In this article, we examine the relationship between veteran health and the loss of identity during military rehabilitation or discharge on medical grounds. Organisational elements of self-identity, that is, how people and groups experience themselves in relation to others (Stets and Burke, 2000), including elements such as collectivism and cohesion, have been core in studying the culture of the military (King, 2006; Kirke, 2009; Siebold, 2007) and transition to civilian life (Brunger et al., 2013). Despite this, these elements have been associated with, but little accounted for, factors in military and veteran health behaviours and outcomes. Based upon our analysis of interviews with 13 members of an Australian high-risk combat unit, who

talked about their personal experience of health and rehabilitation, we examine the relationship between the loss of identity and health during personal rehabilitation within the military.

5.4.1 The culture and health of high-risk combat personnel

The process of becoming a member of a high-risk combat unit usually begins with conventional military training, during which individuals are inculcated with collective attitudes, values, and beliefs, characterised by social embeddedness, attachment, interdependence, and behavioural involvement (Ashmore et al., 2004). This training may be understood as a process of cultural immersion (Kelty et al., 2010; Messinger, 2013) as it changes the way people see the world (Messinger, 2013) and their position in it. High-risk combat units sit within but beyond conventional forces and, as such, personnel are further trained to achieve extra-ordinary tasks of strategic and humanitarian importance (Department of Defence, 2016). The process of creating this force also involves further cultural adjustments as members are admitted into elite and highly cohesive units. A senior military commander (personal correspondence, protected identity, 2015), overseeing the creation and utilisation of high-risk combat personnel stated that:

> Each has volunteered to live in a world where *personalities are less important than the task*, and *the task can only be achieved by a team*. They have subjugated their own egos in order to work together, to stay focussed, to forge a united fighting force. So they don't whine. They don't psychoanalyse. They don't obsess. They do.
>
> Personal communication (2015). Italics added

Although to "do" required tasks will usually necessitate individual operators to push the limits of human endurance and performance, tasks are neither initiated by, nor designed to benefit, an individual. The meaning surrounding "the task" which can only be achieved by a "team" is about doing something important *for* and *with* others. The changed social context of participants, and their cohesive mindsets, will impact how they experience and relate to others, including families, unit personnel and healthcare providers. These factors, however, are little accounted for in understanding health and health behaviours, especially in relation to serious wounding, injury, and illness. This oversight is significant for several reasons: Operationally injured veterans have a decreased quality of life over time, compared to other veterans (Hoencamp et al., 2015); discharge from the military on medical grounds is very common and associated with high levels of comorbidity (Centre for Suicide Prevention, 2014; Ministry of Defence, 2015); and, the long-term health outcomes of veterans in general is complex (Capone et al., 2013; Pietrzak, et al., 2013).

Although there has been substantial academic attention given to these issues, military and veteran health research has been described as reductionist (Shields et al., 2016) with minimal concern for the whole person. This oversight may be a particular issue for high-risk combat personnel, as literature from other fields suggest that high functioning individuals face unique challenges, such as identity disturbance, upon unexpected changes in career trajectory (Parris and Vickers, 2010; Wainwright et al., 2005). We build upon previous work which has helped develop knowledge about how other military personnel subjectively experienced serious wounding, injury, and illness (Bursnall et al., 2001; Messinger, 2010a, 2010b; Wright, 2013) and transition (Aloi, 2010; Brunger et al., 2013; Giger, 2006; Verey and Smith, 2012; Walker, 2013). We do this by offering insight into how high-risk combat personnel experienced themselves in both health and rehabilitation, within the context of their high functioning and cohesive units. This insight may not only contribute to the development of veteran health and transition frameworks, it may also assist in furthering our understanding of human resilience, performance, and organisational capability.

5.5 Participants and method

This study was approved by University of Adelaide and the Australian Defence Human Research Ethics Committees. A qualitative, contextual approach, dialectically positioned between social constructivism and critical realism (Braun and Clarke, 2006; Willig, 1999) to account for the subjective perspective of participants within a necessarily highly ordered occupational setting. A thematic approach was used to analyse the data (Liamputtong, 2013).

Following unsuccessful attempts to recruit through unit-based healthcare professionals, a senior high-risk combat soldier initiated a snowball recruitment method amongst the *brotherhood,* (a colloquial term used by combat personnel). Methodologically, this was essential because of the tight-knit cohort, coupled with participants' reluctance to engage with health professionals. This amendment was approved by the relevant ethics committees, and enabled successful recruitment. Recruitment continued to data saturation, that is, when no new themes related to the research aim were identified in subsequent interviews (Fusch and Lawrence, 2015). This occurred at 13 participants; all were male ranging in age from 32-39. At the time of writing, direct high-risk combat roles were open to females, but none had yet qualified. Participants were undergoing rehabilitation for physical wounds from combat operations (n=8), physical injuries (n=3), and psychological injury and illness (n=2).

Each participant took part in two semi-structured, in-depth interviews conducted by the first author, each interview lasting approximately two hours. The first series of interviews enabled

identification of themes. These were reviewed by the second author, with any differences in interpretation resolved through discussion. The second round provided further insight into identified themes and elicited member validation for further check of accuracy (Bygstad and Munkvold, 2007).

Interview questions elicited discussion regarding the biopsychosocial elements of participants' health and well-being over time, with a focus on their choices and their current situation (see appendix 1). To enable this, interviews evolved to employ a timeline elicitation technique (Sheridan et al., 2011) where the researcher and participant worked with colour coding to assist in developing their perspectives of health and motivation currently and over time. Participants were asked to use blue to mark the timeline in relation to their physical health, with green and red used to represent social and psychological aspects of themselves, respectively. Participants were encouraged to mark the timeline as many times as required to best represent themselves both in health and during change, upon which further prompt questions were asked, e.g. "what does that mean to you?", "can you tell me more about that?" and "what was going on around then?".

This technique proved a helpful tool, enabling participants to make sense of, and re-present, their complex experiences whilst providing a structure for the interview. The figure below represents a typical completed timeline, focused on five significant phases: that of a civilian, conventional soldier, as an operator, during rehabilitation, and projections for the future.

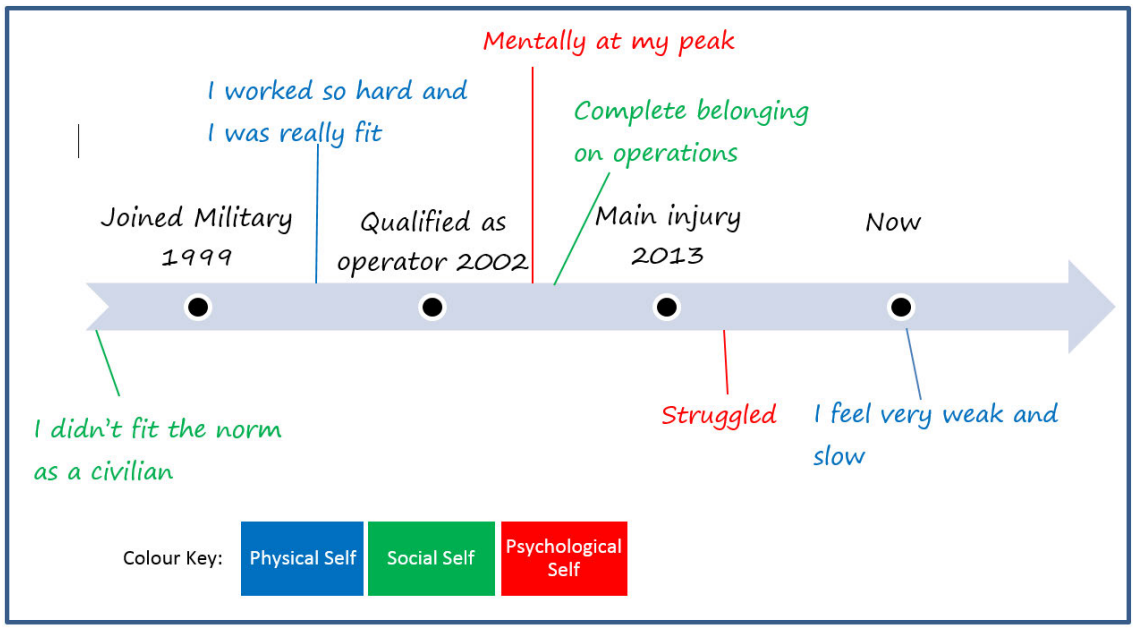


Figure 13. Typical timeline used to elicit participants' perception of self over time

Most interviews were conducted in a private office within a community facility, located on base outside participants' unit. Five participants preferred to be interviewed in or near their homes. During the second series of interviews, two participants were interviewed via telephone as one was training and the other on operational deployment. All data were audio-recorded and transcribed verbatim, with non-lexical speech elements such as "um" "err" and "ah", removed for ease of analysis and reporting (Stiles, 1992). During transcription, identifying information was changed to protect participant identity. The final transcripts were then entered into NVivo (QSR International Pty Ltd, 2012) to facilitate analysis.

Some comment is needed on the role of the first author, who as a military officer, could be deemed to be an *insider*, as she held a degree of cultural insight and was conversant in military language—attributes that enabled her to be taken seriously by and thus connect with participants. Nonetheless, being both female and in a health researcher role, she was also an *outsider*. Anticipation and mitigation of potential real or perceived power imbalances were detailed in both the university and military ethics applications, and adhered to throughout the study.

5.6 Results and analysis

5.6.1 Soldiers' perspectives of themselves

Gaining perspective of participants' self-concept during rehabilitation requires an exploration of how they perceived themselves at the time, and previously. This includes their experiences of themselves as civilians, their stated motivations toward service in the military (i.e. why they enlisted), as well as how they understood themselves in service. With this context established, we then report on participants' experience of themselves during rehabilitation, identifying dominant themes of self-loss, and being in limbo.

5.6.1.1 <u>As civilians</u>

Most participants stated that they were influenced to join the military through a positive narrative of what it meant to serve. Some alluded to identification with family tradition, stating for example, "It was the family history and a bit of pride," while others identified with fictional heroes: "It probably had something to do with childhood heroes and watching movies when you are a kid. It sets up the image of what it is." Some talked about enlistment as a childhood dream: "… from the time I was born, I knew that I would join the Army … there was never any question that I was ever going to do anything else." When participants came of age, earlier positive perceptions were reinforced by tales from serving friends and media reports of international current affairs: "[my friends] told me some of the things they

got up to in the army … I found it very interesting;" and "There is a lot of mystery and so, I guess you fill in the gaps with what you see on TV."

Many participants alluded to an understanding of themselves as having an aptitude for military service. They saw themselves "always quite fit and healthy" and not comfortable adopting "normal" or "mediocre" civilian roles: "I suppose you could say I had an adventurous spirit, and what was perceived to be the norm didn't fit with me at all." Some spoke of "looking for something to belong to" and as being attracted to the challenge and adventure available on the world stage: "Timor started to flare up and it was like 'I really want to get involved with that,'" and "I thought …that looks interesting, looks difficult, looks like a challenge … so I thought I'd have a go."

5.6.1.2 As conventional soldiers

After enlisting, all participants underwent service or training with the conventional army, prior to joining their high-risk combat unit. When discussing this period, participants' reflections on themselves were similar to their views of their civilian selves, wherein they had a "drive for wanting more, … not settling for that life, …not settling for mediocrity." One participant further stated that while training with conventional soldiers he "didn't really feel that connection with anyone, … [I was] almost like a tourist" while others suggested "I don't think I ever fit in with towing the line, … that's never been me." For some, 'not fitting in' was experienced as being perceived as potentially problematic within the conventional army. One participant, who eventually excelled in his high-risk role, reported of this period "I just loathed going into work. I hated having to justify everything I wanted to do all the time," and spoke openly of his occasional insubordination during that period.

Participants also reported being attracted (via recruitment campaigns) to a perceived mystery and challenge inherent in high-risk combat roles, in ways that mirrored their earlier pull towards military service. Of the mystery, one participant recalled "I guess you don't really know [about what they do]. You see those information nights and that sort of stuff, but you don't really know … there's a lot of mystery" while another reflected on the challenge:

> When you are trying to get into a unit like this, you are required to sacrifice so much. and it's one of the things they say to you when you go to the very first meeting, "we want nothing more than 100% from you … if you are not willing to give us 100% it's not worth rocking up." *(5.1)*

Participants also spoke of a respect accorded to these units: "everyone looks up to high-risk units and you think 'that's the place to be', so that's where I wanted to be." Again, they perceived these units as a potential place of belonging "that seemed to be the place where I

was going to best fit into." These perceptions saw participants embrace the challenge of being "the best soldier" possible.

5.6.1.3 As high-risk combat personnel

Having qualified as high-risk combat personnel, participants' perceptions of the role shifted somewhat. One participant reflected "it is an unrealistic expectation that gets you there, but once you get there, it is a different thing that keeps you there." Many described a continual process of change, wherein they were "constantly evolving" and "pushing boundaries." Although challenging, requiring ongoing adjustment between acting as an individual and as part of a team, these were construed as necessary role requirements: "We are always concerned about where we're at as an individual, and where we are at collectively. Who your potential adversaries could be, where they're at, how fast are they [are] developing." A participant described this thus:

> Keep pushing the boundaries. Push and push until someone gets hurt or injured and then it's back off for a little bit, and then you have drawn a new line in the sand, so to speak … and then once you're comfortable with that position, then you start pushing again. *(5.2)*

Somewhat paradoxically, the reported change, challenge, and pain were deemed necessary and positive, as well as inescapable and negative features of the high-risk combat experience. For example,

> You can't keep using the same tactics all the time because the enemy will eventually get used to it. So … you may have to push some boundaries. Those boundaries might be physical boundaries, policy boundaries, equipment or technology boundaries and things like that. *(5.3)*
>
> It gets harder and harder … it just doesn't stop. That's the other addictive thing; it is constant change and constantly having to prove yourself, and it does get massively addictive. *(5.4)*

Perhaps, in part, because of the high-risk and strategic nature of their work, participants consistently described themselves (in the context of their role), as different to, indeed superior to those in other military roles, arguing that "any bloke can do other roles in the army, not everyone can do this," and "when we are away on deployment we feel really important." One participant summarised it thus:

> You are doing the job because you feel value in that role … as a part of the strategic effort in your country's interest, whether it's directly protecting it, or whether it is just doing a task it sees as collectively important enough to send you to risk your life for. *(5.6)*

Critically, the tasks set for high-risk combat personnel were those that can only be achieved by a cohesive team; participants talked about bonding with others in their teams and unit, through mutual reliance and respect:

> You have a bond that is totally different to any other bond … I just know, it's a different type of relationship to every other type of relationship I've ever had. And the biggest thing that drives it is that you don't want to let them down, and they don't want to let you down … you would happily put yourself at risk to keep them out of risk, type of thing. *(5.7)*

Such mutual reliance was essential to the survival of the collective unit but paradoxically required that the individual put their own survival at risk. This can only be achieved through extreme commitment and role competence—which in turn, appeared to contribute to the formation of positive bonds between team members. It was stated that "in our construct, being good at your job is the thing that gives you respect."

5.6.1.4 <u>During rehabilitation</u>

As noted above, it is somewhat paradoxical that, for high-risk combat personnel, "being good at your job," "pushing the boundaries," and "not letting the team down," collectively work to place each individual at increased risk of serious wounding, injury, and illness. This in turn then prevents them from doing that job, thus effectively excluding them from the team. Given the value placed on participants' role by both themselves and others, and the bonds developed through mutual reliance and respect, it is not surprising that the experience of serious wounding, injury, and illness, in the context of their unit, was described as an isolating journey of loss and limbo.

For participants, the experience of serious wounding, injury, and illness (regardless of mechanism) typically resulted in the loss of physical and cognitive function. This loss then impacted their competence, their ability to perform in their role, and ultimately, their sense of significance and belonging. One participant, whose primary health issue was physical in nature, described both a cognitive and physical decline during rehabilitation, explicitly contrasting this with his previous state:

> I feel like it's more absent-mindedness, … Where I just forget things. … I'll put something down somewhere and then I'll leave it there … and I've got to go back and get it. Dumb stuff like that I never used to do. I don't know why I do that. [and] I am looking at the significant physiological changes now, …. I just don't have that natural state of fitness and strength that I used to have. *(5.8)*

Other participants talked about the consequences of serious wounding, injury, and illness using extreme terminology indicating an abrupt disjuncture, and a focus on what was absent. One participant stated "Going from overseas, … you are doing this and you are important and

you are feeling you are doing a good job, and then you get back here and you are doing nothing." Another explained:

> You are working at this level, and then all of a sudden, you're not. For me, that is hitting the brakes pretty hard, … you get to this point where you are not doing anything. You don't have a team. There is no sense of achievement whatsoever. *(5.9)*

For many participants, the loss of function, team membership, shared activities, and role culminated in a lost sense of belonging. This appeared to increase over time, and to follow from the loss of others who mattered to participants, and to whom they mattered:

> Yeah, I'm in the unit and … I could walk over and see them if I wanted to, but … I don't share cages with them, I don't shower with them, I don't do PT [physical training] with them. I'm not a part of that group, …straight away there's going to be a certain amount of disconnect purely because I am not with them. As time goes on, people grow apart. So obviously, that has a direct correspondence to not feeling a part of the group and feeling isolated once again. … It's dramatic. It brings us back to that point of being isolated, of not belonging. As being seen as an outsider… You are on the fringes. You're neither here nor there. *(5.10)*

The experience described here, of being "neither here nor there," is indicative of what participants described as a state of "limbo" or "the unknown" which most reported to experience during rehabilitation. They described themselves as not fully who they used to be, not sure of *who* or *how* they were to become, and no longer having a sense of belonging, either in their units or in civilian society. One participant explained "it's almost like you don't fit in anywhere" and another described his experience thus:

> I am in a bit of a void at the moment. With all these treatments and I have come to terms with the fact I'm no longer going to be an operator … it's like an uncertainty. *(5.11)*

A participant's serious wounding, injury, and illness also disrupted their physical and psychological means of connecting with the self they knew, and with others: "I wake up in the morning and feel like I am 80 years old … . I used to do a whole bunch of hobbies and all that sort of stuff and I don't do that now," and "I rarely go out any more. I rarely go and meet new people, … I find it really hard to connect" which further exacerbated a sense of isolation and lack of purpose.

Whilst in limbo, participants actively resisted potential labels which may have been applied to them by clinicians, peers, and society at this time. For many, this appeared to centre on a refusal to be defined as the antithesis of what had been a defining feature of their previous lives—as active soldiers who achieve challenging, important, tasks of national significance.

Participants talked of needing not to be considered a "victim," as not "reliant [or needing] special treatment," and some expressed hopes that their primary identity did not become that of a wounded or disabled veteran, for example:

> … those on the DVA [Department of Veterans' Affairs] benefits, … a lot of them, being a veteran is their identity. That is their life. Without it they have nothing, … whereas it is nothing to me, … it is not something that I'll let define me. *(5.12)*

They further spoke of feeling helpless and becoming a liability during rehabilitation. These feelings of helplessness were particularly evident in the acute phases of injury or illness and often consequent upon changed physical states; they were also affirmed or exacerbated throughout the rehabilitation process as their changed selves interfaced with their peers, the military, the health system, and wider society. Again, this state was experienced as a complete reversal of all that they had been before. One participant expressed this as "you go from being in a very enabled position to 'What do you mean I can't even do this and I can't have access to that?' What the f*** is going on here?" Another explained the feeling as:

> The feeling that this wasn't me. I just felt like I'm not a person that should be in a wheelchair. And the fact that I had no control over that whatsoever is really, um, frustrating… I just didn't like that feeling of helplessness I suppose … I didn't like putting people out … I felt like I was putting people out. *(5.13)*

Some spoke similarly of loss of "choice," "freedom," and "control," describing how they came to see themselves as a liability to the collective, rather than a contributor to it. One participant remarked "I am actually a liability now—definitely a liability," and another said "It was almost like you were either fully operational or you were an isolated broken reject." Not surprisingly, these feelings were associated with feelings of self-dislike, shame, and embarrassment. Some participants described feeling "really disconnected and ashamed" and talked about their self-depreciation thus:

> I was starting to doubt myself and second-guess my actions and my future and things like that. I just wasn't sure what was happening. Physically I lost my physical well-being which is big for me, therefore my confidence went down-hill a bit ... I couldn't do the things I wanted to do, with my mates and with my wife. …and now I am just one of those busted blokes at work … and I never thought I would be. I've never been on a chit [medical leave certificate] in my life, I've never been downgraded. And now, I'm like, at the bottom, …for me, it's disgusting. *(5.14)*

One participant cogently described his feelings of frustration, anger and, depression:

> I still get pissed off at things that are different, and what I can and can't do … it is extremely frustrating. I have limitations. My limitations are not chosen… [and] I still have days where I feel depressed. You go through

> stages where finding self-motivation is so hard now... You will be really good for a week and then "I can't be bothered getting out of bed today." *(5.15)*

The terminology employed here, of being "busted," "down-graded," and "at the bottom" may reflect and constitute subjective feelings of loss, or being devalued. These were also present in participants' talk about changed relationships to themselves, their job and their team:

> It was heart-breaking. I had worked so long and so hard to do it. And having loved the job so much, and most importantly, working with the boys. I knew that wasn't going to happen anymore. … I don't really want to see anyone. … I feel embarrassed, … It's a feeling like I am letting them down by not being there. *(5.16)*

In circumstances where their loss or lessened state might be observable to self, or others, some participants hid—avoiding encountering others, and using alcohol or prescribed medication to hide from themselves:

> I was abusing prescription medication for a fair few months there … . Yeah, I was most definitely abusing them. Without a shadow of a doubt I was abusing them. … So what else was I going to do? So I was sitting at home, doing endone. … I just lost all hope. I just lost all hope. And my physical state just deteriorated. I just looked f***ing yellow. *(5.17)*

At the extreme, some participants reported thoughts of self-annihilation. One participant explained "I guess you don't want to be here anymore. You just want to kill yourself. Basically, I was just done." Such participants seemed to be particularly sensitive to the experience of self-loss, as the person they previously understood themselves to be no longer existed. This experience of a lost *personal* self, was clearly coupled with a lost *social* self, through loss of role, significance, and relationship with valued peers, with whom participants were bonded. Participants' talk of wanting to end their own lives seemed to represent their desire to actualise their psychic reality during transition: going from being some-one, to being perceived (and thereby perceiving themselves) as no-one.

5.7 Discussion

As adults, participants were admitted to the conventional military and later selected for service in their elite and highly cohesive unit. Through training and operating in their roles and in their teams, participants established a strong sense of belonging which, in turn, contributed to their sense of identity, health, and wellbeing. Through serious wounding, injury, and illness, this identity was sharply disrupted and followed by a cascade of loss, experienced as lost function, role, and sense of belonging. Over time, their loss gave way to a state of limbo, both being associated with negative affective states, such as anger, frustration,

depression, and anxiety, as well as self-discomfort and dislike. At the extreme, some participants engaged in self-destructive behaviours and suicidal ideation. Although these states and behaviours can be traced back to lost physical and cognitive function, most participants focused on the impact of their lost social-self (lost role and lost sense of belonging) as critical to how they came to experience themselves.

Within the military, much attention is afforded to the functional aspects of health, and the restoration of it (Messinger, 2010b; Shields et al., 2016). Our findings, however, support previous arguments that, within the military context, explicit wounds and injuries to the physical self often overshadow damage, or needs related to other parts of self (Gerber, 2012; Messinger, 2010b) which are of equal importance to individual health and wellbeing. In the below, participants' subjective experiences and subjectivity following serious wounding, injury, and illness will be theorised through employing a *self*-related framework to encompass self-development and self-loss over time, and applying the concept of liminality to understand their state of limbo during rehabilitation. In addition, we will examine participants' experience of themselves, inclusive of their negative affective states, thoughts and behaviours, through using Emotional-Focussed Theory.

The notion of self is of interest across academic disciplines and health-related fields, including sociology, psychology, anthropology, neuroscience, and medicine, with associated variation in orientation, language, and scope (Stets and Burke, 2000). In psychology, the self is understood in terms of an individual or personal phenomenon (American Psychiatric Association, 2013), sociology places emphasis on collective and social influences of groups, categories and roles (Vaughan and Hogg, 2005), whereas in anthropology self is situated within a cultural context (Morris, 1998). Unifying these various understandings of self across disciplines is the understanding that self is both a social and cognitive construct, being the phenomenon which connects people to others and their world (McIntosh, 1995; Van der Kolk, 2014). Self, as a connective function is also evidenced in neuroscience which has mapped self-other correlations in the brain (Araujo et al., 2011; Qin and Northoff, 2011).

Notwithstanding these various academic and clinical nuances, the concept of self most likely to be implicitly or explicitly accessed by those caring for veterans, is from the field of psychology. In this context it is useful to consider the fifth edition of the Diagnostic and Statistical Manual (section III) definition which suggests that 'self' is the sum of a person's identity and their sense of self-determination, or agency (American Psychiatric Association, 2013). In this study, both identity and sense of agency are disrupted in participants during

rehabilitation. The importance of this, within a therapeutic context, was highlighted by Marks et al. (2000) who asserted that understanding health behaviours involves more than knowledge of disease; it includes an appreciation of a person's sense of self, including self-definition, self-efficacy, social supports and belief systems.

Despite the centrality of self within academic and therapeutic discourse, consideration of the self, as a person's sense of identity *and* sense of agency, appears to be under-represented within the field of military rehabilitation and transition. For participants, the process of rehabilitation and transition appeared to demand reappraisal of their sense of self, implicitly or explicitly requiring them to reconstitute or re-develop their identity, or, their self. Such concepts are largely positioned within psychosocial *developmental* frameworks, rather than military rehabilitative frames. Within developmental frameworks, adolescence is generally accepted as the primary life stage in which selfhood is developed (Erikson, 1966; Kroger, 1996). In adulthood, however, significant change may come to *alter* a sense of self. In this context, rehabilitation can be understood as a task of self-*re-development.*

Change to a person's sense of self, may be experienced personally, or socially—the former when function is impacted through injury or illness (Collinson and Hockey, 2007; Ellis-Hill and Horn, 2000; Wainwright et al., 2005) and the latter when an individual shifts between social or cultural contexts (Hermans, 2001; Ward and Styles, 2003). A person's identity or sense of self may also change as a result of exposure to traumatic events (Berntsen and Rubin, 2006; Brewin et al., 2011). These circumstances, and their impact on the self, were all evident amongst participants, who emphasised the sense of loss they experienced as a result of social dislocation and separation from their cohesive teams.

The theme of loss, following change, was coupled with a feeling of limbo. Through an anthropological lens, this state of limbo may be understood as akin to *liminality*. In this state, participants are no longer who they were, but had not (yet) developed a new way of being, and thus experienced high levels of ambiguity, confusion, and marginalisation (Turner, 1995). Whilst liminality has begun to influence ideas around military to civilian transition (Demers, 2011; Herman and Yarwood, 2014), and has increasingly informed understanding of health and illness (Jordan, Price, and Prior, 2015), it features neither in the discourse of military rehabilitation nor within veteran individual therapeutic modalities. This may have consequences: for example, as participants moved into a liminal space—being neither what they were nor yet what they might become—the lack of language to express and reflect upon their own experiences could logically engender feelings of anger and frustration, as well as

depression, anxiety, self-discomfort, and self-dislike. This may be exacerbated by perceptions of having had, and lost, a strong and valued identity, of becoming precisely everything they had characterised themselves as *not-being* (quote 5.13 'this just isn't me'—being indicative of the limited positions available to them).

The relationship between the participant's anger and frustration on one hand, and self-discomfort and dislike on the other, may be framed using Emotional-Focussed Theory (EFT). According to EFT, anger is related to criticism or hate, which may be directed *inward* "I hate me" (i.e. for being "busted" or "at the bottom"), *outward* "I hate you" (i.e. for no longer accepting me), or, it may be directed both inward and outward "I hate everybody" (Pascual-Leone et al. 2013, pp. 84-89). Regardless, it follows that anger, hate and loathing may be means to cover or counter feelings of passivity, weakness, or vulnerability (Pascual-Leone et al., 2013). The feeling of anger, particularly as it relates to feelings of subjective loss, is known to mediate risk-taking behaviours (Beisswingert et al., 2015), and indeed, some participants engaged in self-destructive and risky behaviours, as well as suicidal ideation during rehabilitation. Although present and unwelcome in the participants' experience of rehabilitation, such feelings are predictable, even normative within the context of liminality.

Given what is known about self and liminality, strategies to support military personnel (especially those in high-risk combat roles) during times of change may benefit through using existing knowledge within a new context. Although the state of limbo, or liminality, is largely situated as an anthropological or sociological phenomenon, similar themes have been evident in psychotherapeutic theory since the mid-20th century. Liminality may encompass what Erikson called *identity moratorium* (1956) and what Winnicott called the *doldrums* (1965). These theorists, whose ideas were founded on object-relations theory, considered liminality as a normal process of identity development, recommending that society should view it "as a permanent feature and to tolerate it, to react actively to it, in fact, come to meet it, but not cure it" (Winnicott, 1965, pp. 85-86). Liminality may offer an opportunity for growth, suggesting that operators need support, not fixing, when they exhibit difficult behaviours and negative emotions during rehabilitation. An understanding of self-development and re-development might also assist the field of veteran and military health to further promote a person-centred approach to veteran rehabilitation, using a self-framework which accounts for the whole person over time (Shields et al., 2016).

5.8 Recommendations

Building upon the experiences shared by participants, it logically follows that psychosocial therapeutic interventions and supports that address issues of loss, limbo, and negative experiences of self may complement current rehabilitation processes offered within the military health and rehabilitation systems. This will require further research that articulates and analyses the subjective states of operators and other military personnel during times of change, within the cultural contexts of their units. This will enable the development and use of culturally-appropriate language in the process of understanding, communicating, and normalising lived experience. Such research might also consider established psychosocial frameworks such as those developed by Erikson (1956) and Winnicott (1965), which successfully incorporate human development and concepts of liminality. These frames may be usefully employed in diagnostic and clinical health assessments, as well as in the development of veteran specific therapeutic interventions. The object relations basis to these theories, which emphasise the importance of identification (or in this case, re-identification) through relationship (Winnicott, 1965) suggests that the support of high-risk combat personnel who have successfully negotiated challenges to self may be crucial in helping other veterans navigate similar change. Finally, noting that liminality involves both loss and growth, further analysis might also focus on the latter, on themes of self-growth and adaptation experienced during rehabilitation.

5.9 Conclusion

This analysis suggests that military and veteran health behaviours are highly socially contextual, and, that a lost sense-of-self contributes to a variety of comorbid health issues within this population. The military is a distinct cultural group, and high-risk combat personnel are further distinguished from civilian society, therefore efforts to assist these veterans during recovery and rehabilitation will need to be uniquely tailored to meet their needs, acknowledging and addressing the cultural elements of the military and their units. To achieve this task, it may be critical to further understand, through a constructivist lens, how veterans and military personnel experience themselves during times of change such as during rehabilitation and transition, and in relation to specific unit culture. Given the idea of self may be a central yet relatively unexplored dialogue in fields of veteran and military health as it relates to rehabilitation and transition, academics and clinicians would be also well positioned to re-visit existing theories which relate to human development, such as those proposed by Erikson (1956) and Winnicott (1965). This revisitation may enable the military and civilian

communities to better understand and support military personnel and veterans during times of significant change as they *re-develop* their identity, thereby contextualising and normalising some of the more difficult experiences. This approach may facilitate collaboration between health researchers and other human-based military researchers who hold an interest in resilience, human performance and organisational capability, as well as contribute to the development of veteran specific healthcare frameworks and psychotherapeutic modalities. Most importantly however, it will allow for the provision of culturally and contextually sensitive care for those who have given so much—our veterans.

Chapter 6. Values and behaviours associated with soldiers' adaptions to serious wounds, injuries, and illnesses in the Australian Army

6.1 Preamble

Previous chapters have outlined the ways that a sense of self is developed, defended, and lost in the studied population. Self-constructs came to be situated in participants' ability to perform in their roles, which enabled them to operate as a part of a highly trusted team that accomplished tasks that were valued by the nation and thereby the individual (e.g. see quote 5.6). These self-constructs were reflected in participants' talk about health which related to having a sense of personal agency and interpersonal trust, which in-turn, enabled collective capability. Although highly adaptive in context, a sense of self (thus defined) increased participants' felt identity in their role, but also came to undermine a personal sense of it. This over-identification with their role came to impact their relationships with those who did not share combat experience, including clinicians. Healthcare avoidance, therefore, was underpinned by a felt erosion of identity outside their role and a lack of trust in those who could potentially remove them from it through a medical "downgrade" (e.g. see quotes 4.21 and 5.14). The term downgrade used here is important because it represents devaluation of the individual by the system, which later became an internalised self-representation.

The participants and others placed a high *value* on their role as high-risk combatants, and participants described feelings of devaluation when their role was no longer available. Within the military, value and values are important constructs, with a defined set of them inculcated through recruit training. Just as values inform adaptation *to* the military, this chapter highlights the values participants drew upon as they adapted to their changed state through rehabilitation and transition. Results suggest that a unique set of values underpinned sequential stages of adaptation, providing insight into this dynamic psychosocial process. Based on the findings, a values-based model of psychosocial adaptation to military rehabilitation and transition to civilian life is proposed.

6.2 Statement of authorship

Title of paper: Values and behaviours associated with soldiers' adaptions to serious wounds, injuries, and illnesses in the Australian Army

Principal author

Name of principal author (candidate): Paula Dabovich

Contribution to the paper: Conducted literature review, devised scope, aim and interview questions. Planned and conducted interviews, transcribed, coded and analysed data. Composed and wrote article.

Overall percentage: 85%

Certification: This article documents original research conducted by Paula Dabovich as a part of her higher degree by research candidature. It is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. Paula Dabovich is the primary author of the paper.

Signature: Date:

Co-author contributions

By signing the Statement of Authorship, each author certifies that:

6 the candidate's stated contribution to the publication in accurate (as detailed above);

7 permission is granted for the candidate to include the publication in the thesis; and

8 the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of co-author: Associate Professor Jaklin Eliott

Contribution to the paper: General oversight and monitoring of research design and conduct including question design, data collection and analysis. Provided structural feedback and editorial guidance on manuscript.

Signature: Date:

Name of co-author: Professor Alexander McFarlane

Contribution to the paper: General oversight of research and provision of strategic guidance. Provided feedback on manuscript.

Signature: Date: 20/04/2018

6.3 Abstract

Background: Many negative health behaviours and outcomes in veterans can be attributed to problems of identity; identity is in part informed by fundamental values. Despite this, the ways that values impact on health behaviours and outcomes have received little examination within the social sciences and veteran health discourse. This oversight exists even though values are critical to many service organisations that require unity in unstable or dangerous environments, such as the military. The intersection between values, identity, and veteran health behaviours, therefore, remains relatively unexplored. **Aim:** In this article, we examine the relationship between values, behaviour, and adaptation to serious wounds, injuries, and illnesses, as experienced by 13 high-risk combat soldiers undergoing rehabilitation and transition to civilian life. **Method:** Two semi-structured, in-depth interviews were conducted with each participant over nine months. Data were thematically analysed using a qualitative, social constructionist paradigm. **Results:** Upon serious wounding, injuries, and illnesses participants were unable to perform their roles or remain in their teams. After an initial period of loss and feelings of limbo, those with physical (rather than psychological) limitations drew on four sequential clusters of values that informed behaviours, and are here documented as stages. The first stage demonstrated a shift from habitual forms of pushing, to that of reflection. This shift was underscored by humility and enabled participants to accept their limitations and gain perspective. Second, compassion and gratitude helped to build and repair relationships. The third stage featured a moment of choice which was followed by hard work, and enabled participants to individuate and separate from the collective. This stage involved effort, and was underpinned by a sense of personal integrity and responsibility, along with passion and perseverance. Finally, these participants came to experience a more developed and complex identity which compelled them toward mature forms of contribution. In short, the first two stages involved self-other rebalancing, and the third resembled the individuation and separation process normally associated with the psychosocial task of adolescence, which enabled mature contribution. Those with psychological conditions did not share this trajectory but rather became stuck in prolonged feelings of humiliation and guilt. **Conclusion:** The study of values provides insight into the process of identity re-development in military personnel undergoing rehabilitation and transition, and results suggest this process was akin to the self-other rebalancing, and individuation–that is, the separation task of adolescence. This insight has theoretical, clinical, and policy implications and may serve to inform overarching primary healthcare strategies as well as a transition research agenda.

6.4 Introduction

Military organisations are responsible for managing global violence and instability on their nations' behalf, thus enabling civil society to pursue liberty-based activities such as business, artistic, and sporting endeavours, relatively undisturbed by trauma and horror. As a consequence, many of those who have served in the military have different health outcomes and behaviours, compared to those who have not (McFarlane et al., 2011; McFarlane, 2017; McLeay et al., 2017). Veterans experience psychological problems such as post-traumatic stress disorder (PTSD), anxiety and affective disorders, at higher rates to those in the civil community (McFarlane et al., 2011). They also have high rates of isolation, homelessness (Bryan and Rudd, 2012; Goldstein, Luther, and Haas, 2012), self-destructive behaviours including substance misuse (Hines et al., 2013; Maguen et al., 2011; Pietrzak et al., 2013), and suicidality (Australian Institute of Health and Welfare, 2017; Maguen et al., 2011; Parliament of Australia, 2017; Pompili et al., 2013). For the most part, all these involve the issue of disrupted identity, either as a cause or consequence of the outcome or behaviour (Benda, 2004; Benedik, 2008, 2009; Brewin, Garnett, and Andrews, 2011; McAllister, 2003).

Identity represents a person's subjective, coherent sense of themselves over time (McIntosh, 1995) as well as in relation to others; it therefore involves objective social elements such as roles and expectations (Erikson, 1979; Heidegger, 1962; McIntosh, 1995). Identity is both subjective and objective, therefore it is considered a dynamic psychosocial concept that is modelled and remodelled throughout life, in relation to a person's unique experiences of the world (Erikson, 1968; Feeney, 2008). Although identity is updated throughout life, the most sensitive periods of this development are currently considered to be in the first three years of life, and in adolescence (Blos, 1967; Erikson, 1968; Kroger, 1996; Mahler, 1974).

The military places enormous demands on a person's sense of identity. First, personal identity is actively shaped in relation to needs of the collective, by way of recruit training (Demers, 2011). This process may be understood to subjugate many personal choices afforded to civilians that go some way in expressing identity, such as clothing, hairstyles, and possessions, and turn them more strictly toward their role and function in their role (Laberg et al., 2010). Furthermore, identity is widely understood to be disrupted by trauma (Berger, 2015; Van der Kolk, McFarlane, and Weisaeth, 1996), exposure to which is inherent to many military roles. Finally, identity is again challenged during military to civilian transition when a collective identity, forged to operate amidst danger and instability, must give way to that appropriate to civil society (Shields et al., 2016). This transition can place significant

demands on the individual as they come to experience the world very differently in relation to service life:

> The magnitude of displacement that occurs with discharge is enormous. They simultaneously lose their home, job, friends, role, status, income, leisure, security, identity … every defining characteristic is altered, creating a massive displacement … the degree of loss experienced by these participants would be difficult for civilians to understand.
>
> Bursnall, Kendall, and Wilcox (2001, p. 219)

One of the forces that is understood to bind collective organisations and help to create collective identity is that of values (Forces in Mind Trust, 2013; Hitlin, 2003; Joas, 2000; Ward and Styles, 2003; White, 2001; White, 2007). Values represent what is considered good to individuals and groups, and thereby guide what is desired, perused, or defended (Bednarek-Gilland, 2015; Schwartz, 2017). Due to the link between values and the actions of pursuing or defending, they are closely tied to issues of motivation (Bednarek-Gilland, 2015; White, 2007).

At an individual level, values can be difficult to conceptualise and thereby are often experienced as relatively abstract; accordingly, people can find it difficult to instantly locate, name, and verbally express their values when asked (Bednarek-Gilland, 2015). Despite this difficulty, values enter personal awareness easily, by way of emotion, when they are violated:

> Emotions connect us to the world, and emotional reactions, at times strong and passionate ones, are always in the offing when we are confronted with things we care about. We could say therefore that the act of valuing is … emotional; it is the conscious expression of an interest, [or] a motor-effective attitude' (Dewey, 1966 [1939], p. 5).
>
> Bednarek-Gilland (2015, p. 17)

Bednarek-Gilland (2015) has asserted that the connection between values and emotions rest on the notion that values "register at a basic dispositional level of our existence" (2015, p. 16), and thereby relate to what matters most—a notion shared with other thinkers in the field (cf. White, 2004). Based on these assertions, it is likely that values are associated with the perceptual or implicit memory system in which emotionally significant events are recorded and later triggered into consciousness by similar emotional stimuli. This memory system is thought to sit in parallel with episodic memory which is associated with details of events that can be voluntarily recognised, recalled, and verbally expressed (Brewin, 2014). Regardless, the 'basic dispositional level' at which values are imprinted in the psyche means they are transferrable between situations, and relate to *both the self and others;* these features

differentiate values from more individualised and situationally dependent constructs such as beliefs and attitudes (Bednarek-Gilland, 2015; Schwartz, 2017).

For the most part, what a civilian considers to be of value, from a psychosocial standpoint, is implicitly inculcated in the primary family unit, and these guide identity, relating, and behaviour (Bednarek-Gilland, 2015; Joas, 2000). In addition to the values acquired in a family unit, the military inculcates a set of values in those who volunteer for service, and this occurs within a social context similar to that of a family. In both these contexts, the subjects of inculcation have vertical attachment figures (leaders akin to parents) and horizontal attachment figures (peers akin to siblings). The shared values, therefore, help military personnel identify with and depend on one another for survival (Manning, 1994; McIntosh, 1995; Siebold, 2007; Wessely, 2006).

The values of the Australian Army are courage, teamwork, respect, and initiative (Department of Defence, 2017) and these are similar to those shared by other nations (see Figure 14 below). Such similarities suggest there is a transnational awareness of the values necessary to succeed in war, most of which are of selfless or prosocial orientation (Fox and Pease, 2012; Hughes, 2013; Manning, 1994; Schwartz, 2017; Wright et al., 2013).

Australian Army[1]	United States Army[2]	British Army[3]	New Zealand Army[4]
• Courage • Teamwork • Respect • Initiative	• Courage • Loyalty • Respect • Honour • Integrity • Selfless service • Duty	• Courage • Loyalty • Respect • Discipline • Integrity • Selfless commitment	• Courage • Comradeship • Commitment • Integrity

[1]Department of Defence (2017)
[2]United States Army (2017)
[3]Ministry of Defence (2017b)
[4]New Zealand Army (2017)

Figure 14. Values of the Australian, United States, British, and New Zealand Armies

Other scholars have noted that the identity of military personnel is, to some degree, based on familial ties to others (expressed as fictive kinship), as well as selfless participation in national or global events (Woodward and Jenkings, 2011). These values and behaviours may

be usefully considered as *prosocial* because, for the most part, they ultimately place the needs of the collective over the individual (Schwartz, 2017), further expressed thus:

> … by establishing identity based on group ideology, the individual becomes less concerned with their individual matters and more devoted to larger, institutional causes.
>
> Griffith and Vaitkus (2010, p. 48)

When prosocial organisational values are shared, they represent the glue that coheres the military, thus enabling team performance amidst global violence and instability. Accordingly, within the academic literature, military values have featured in relation to performance (e.g. Griffith and Vaitkus, 2010; Kjærgaard et al., 2013; Laberg et al., 2010), culture (Ashley, 2013), and resilience (Marcellino and Tortorello, 2015), yet only a few scholars have attended to them in relation to transition after deployment or upon return to civil society (cf. Demers, 2011; Ly-Turnbull, 2011 and Messina, 2015 in Shields et al., 2016). This omission exists even though the adoption of collective, selfless, or prosocial values are critical to military success, and have been implicated as a factor that can predict PTSD and other mental health disorders after deployment (Zimmermann et al., 2014a; Zimmermann et al., 2014b). Some leading scholars have even gone so far as to suggest that clinicians should remain neutral in the matter of values after trauma or seismic life events (Calhoun and Tedeschi, 1999), whilst others suggest they are an outdated construct within the social sciences (Bednarek-Gilland, 2015). Despite this tacit dismissal of values, they remain critical to the military and those within it (Hitlin, 2003; Joas, 2000; Ward and Styles, 2003; White, 2001; White, 2007) which suggests that our understanding of the documented challenges faced by those transitioning out of the military might be enhanced through an examination of the values expressed by those so transitioning.

6.5 Method and participants

This study was approved by the University of Adelaide and Australian Defence Human Research Ethics Committees. A qualitative, social constructivist approach using thematic analysis (Liamputtong, 2013; Willig, 2012) was employed to study the subjective experience of military personnel who operated high-risk combat roles, as they underwent rehabilitation for serious wounds, injuries, or illnesses. This approach enabled the identification and examination of the values participants drew upon, and the extent to which they related to health and adaptation from serious wounds, injuries, and illnesses.

Recruitment was conducted using a snowball method which was initiated by a senior soldier undergoing rehabilitation. This enabled recruitment until data saturation which occurred at 13 participants (Fusch and Lawrence, 2015). All were male, aged between 32-39, and rehabilitating from physical injuries (n=3), physical combat wounds (n=8), and psychological injury and illness (n=2). Given the small number of those with psychological injuries and illnesses, the extent to which findings may be applied to similar others may be limited.

Each took part in two semi-structured, in-depth interviews with the first author, and each interview lasted approximately two hours. The interviews elicited discussion about the ways that participants adapted to changes in their physical, social, and psychological health, with a focus on their current situation, motivations, and behavioural choices. As the study progressed, interviews evolved to incorporate a timeline technique (Sheridan, Chamberlain, and Dupuis, 2011) where visual representation of past, present, and future was developed in relation to each health domain (see Chapter 2). Questions such as "what was important to you then?" "what were you aiming for?" "what motivated you toward that?" and "what is important to you now?" were typical. As values are a psychosocial construct (i.e. they represent what matters to both the self and others), questions were also asked about participants' perceptions of peers undergoing rehabilitation, for example, "what is it you admire about that person?" and "what do you think helps that person through rehabilitation?" Once established, codes and themes were identified in relation to several research questions and reviewed by the second author with any discrepancies between the first and second author resolved through discussion. Themes were then discussed with participants in the second series of interviews, which enriched the data and served to check accuracy through participant validation (Bygstad and Munkvold, 2007).

Most interviews were completed in an inconspicuous, on-base facility, external to the participants' regiment, and five were conducted near their homes. For the second interviews, two participants participated via telephone as one was on a training exercise and the other on operational deployment. Both the first and second series of interviews were audio-recorded and transcribed verbatim, except for identifying information, which was altered to protect participants. Speech utterances such as "um" "ah" and "err" were considered non-lexical and omitted during transcription (Stiles, 1992). The text was then entered into NVivo (QSR International Pty Ltd, 2012) for coding and thematic analysis.

This chapter is the final in a series of four. The first related to the affective experiences of combat (see Chapter 3); the second, to the meanings attached to health and illness, and the

impact of these on health behaviours (see Chapter 4); and the third related to the relationships participants had with themselves and others during rehabilitation, and the behaviours these prompted (see Chapter 5). These three papers demonstrated that identity was forged in combat by way of affective states brought about by their tasks, and in relation to their teams. Paradoxically the strength of this felt identity rendered it vulnerable in situations outside the combat role—a phenomenon that underscored healthcare avoidance and prompted strong negative emotions and behaviours during rehabilitation. For this final chapter, data were specifically coded and themes identified for the values that participants drew upon in rehabilitation and transition to aid psychosocial adaptation, that is, the way they came to rebalance their relationship between themselves and others.

6.6 Results and analysis

Participants with physical wounds, injuries, and illnesses adapted differently to those with psychological concerns. Analysis of the speech of those with physical conditions suggested three critical stages of adaptation, each of which drew on a distinct set of values that helped them overcome a lack of direction, and feelings of humiliation and guilt. In the first stage, participants gained self-awareness through reflection—a process which involved humility. Next, compassion and gratitude toward others helped participants to build relationships with those they had previously been unable to identify with, and to repair them with those they had previously taken for granted. Building on the former two stages, some participants were able to find a new personal direction, and thereby psychologically separate from the collective. This involved a moment of choice and hard work, characterised by personal integrity and responsibility, as well as passion and perseverance. The speech of those with psychological conditions suggested they did not move through these stages, but remained directionless and overwhelmed by feelings of humiliation and guilt.

6.6.1 Stage 1: From pushing to reflecting

Rehabilitation was characterised by two forms of adaptation, which, based on participants' language, have been named *pushing* and *reflecting*. Pushing was described as their habitual means of adaptation which involved achieving and surpassing clear goals—a process that was mostly outwardly orientated and observable to others. In contrast, reflection involved looking inward and gaining self-awareness.

Participants talked about pushing as the way they trained and operated as soldiers, establishing this as how they formerly overcame challenges—they pushed up, against, and through real or perceived boundaries:

> You can't really do this job unless you are the type of person that likes to push the boundaries. *(6.1)*
>
> You are always trying to push, I suppose you are always trying to prove you are what a high-risk soldier should be, … fairly smart, very fit, uncompromising in their willingness to do what it takes to get the job done. Strong work ethic. *(6.2)*
>
> … you always want to be better. …there is no room for you to stop, because if you stop developing and you stop pushing the envelope, … and no-one else is stopping … you could potentially lose. *(6.3)*

Most participants aimed to return to their previous role and this necessitated observable behaviours that mirrored the way they had pushed previously to overcome challenges in both training and operations. Most participants talked about pushing the boundaries as a need to constantly strive toward or surpass something:

> … we are constantly pushing for higher standards. … The next level up is potentially an unknown but it won't stop us from striving to get to the next level up. Somebody says 'you can't do it', that's more motivating, but also, if you try and tell me and if you try and stop me from doing that. If you give me a goal that is easy—I am not interested. I am just not interested. It must be the same as when kids revolt against their parents, maybe. I don't know the psychology of that. *(6.4)*
>
> You are striving to do something better … striving for more and better things. *(6.5)*
>
> It is something I enjoy. What's next? What's new? What can we do? How can we be better? It's almost a creative urge. *(6.6)*

Self-awareness became heightened when pushing was no longer effective, through lost role (as may occur with dislodgment from their team), lost capacity to push, or both. For many, these losses prompted feelings of vulnerability, embarrassment, and humiliation. Unlike pushing toward the attainment of outward goals, gaining self-awareness drew participants inward. In contrast to their previous experiences of pushing through a boundary in the context of being (seen) with and by others, this activity demanded humility and involved—and was thereby only observable to—few others, if any at all.

For the most part, participants continued pushing in rehabilitation, especially when previous ideas of themselves were adhered to, along with the desire to return to their previous role.

> I want to get back to full fitness and get back into the job. That's the goal, and that's the only goal, and they go hand in hand. The full fitness equals getting back to the job, getting back to the job equals full fitness. I don't spend any time thinking about anything else beyond that. *(6.7)*

For a small minority, maintaining such a restricted goal, as in, "That's the goal, and that's the only goal," and pushing toward it, proved adequate to return to former perceptions of themselves; for most, however, this placed them in an all-or-nothing situation. When pushing

became insufficient, often accompanied by a revelation and recognition of the overwhelming nature of their wounds, injuries, and illnesses (that saw them unable to be who they once were or perceived themselves to be), participants talked about feelings of vulnerability and embarrassment.

> So mentally [after serious wounding] I was still at my peak. I was pretty banged up, but in my mind, I was like "no, three months, I'll be good to go." I was trying to push every-single-thing. And the rehab team were like "No, you've got to back off!" and I was like "No! What do you know? ... I can do this!" Because I pushed myself so hard through a whole career and this was just another little speed bump to me, and only now, I'm starting to realise (it's been almost a year) that they were right. It's a long process. *(6.8)*
>
> … it was just like "S**t! I was so invincible, and now I'm not!" *(6.9)*
>
> I think some people might be embarrassed about it, … they have completed their rehab as much as they can, …they are pushing, pushing, pushing and keep going and keep going, but it's not happening. Then something's got to give, and it may be physical or it may be mental but it is most likely to be mental; … they are probably going to go backwards a lot, and it is going to spiral and snowball and snowball and snowball. *(6.10)*

Perhaps due to the failure of their habituated response (of pushing) to challenges, the statement "something's got to give" indicated a crisis, at which point, change needed to occur. For some, the crisis manifested at work, and for others it occurred in the home, as indicated by comments such as "things were getting really bad at home, … something had to happen." With an inability to return to their role, push through, or push past boundaries (a highly prized quality which enabled a high-risk combat career), and without ideas of themselves for future, participants suggested that the build-up of pressure demanded some form of relief. Some participants talked about relief by way of a breakdown (as in the above), and others talked about it by way of thinking and reflecting:

> You try lying in a hospital bed all day. All the thinking you do. You do a lot of thinking. There are so many "what ifs" that come into it. *(6.11)*

Although participants undoubtedly engaged in reflective practices during their training and operational service, doing so in a highly individualistic rehabilitative context—without a team, without a collective goal, and without outward boundaries—involved many reactions related to loss and the unknown, such as panic and anxiety:

> I started having panic attacks some mornings, … you would press the button for a nurse to come and nobody comes, so that gave me a sense of helplessness which lead to the panic attacks. So I had no way of doing anything about it because I couldn't walk. So I'm stuck in bed, massive amounts of pain, no-one there to help me. Panic attack. So a very stressful time. *(6.12)*

Helplessness, as a consequence of wounding, injury, or illness, was antithetical to the participants' former selves. The inability to "do," combined with a lost sense of support, "[there was] no-one there to help me," necessitated less behavioural activity, less reliance on others, and more self-awareness, achieved through increased reflection. Forced through loss of the collective, sometimes this reflection occurred alone but at times, it occurred through talking with others.

> I was saying [to my civilian friend] how miserable it was because I couldn't go back … He goes "… for the last ten years or so, what you have truly loved. You don't have to prove yourself anymore. You have done more than we ever have in our life, for this country. If you have to try your hand at something else, is that such a big deal?" And that really hit home for me … I pondered that for a long time. I thought to myself "I am so stuck in this high-risk army bubble, that's all I see …". When I take myself out of that … and look at it objectively, what they were saying was absolutely right, … my body still worked. I was still able to pick things up off the ground and go for a walk. … I could have found something I was modestly interested in and make a living. … That was the first time that I have sat back and thought, "maybe this wouldn't be such a bad thing." *(6.13)*

> I give myself wakeup calls. I'll sit out the front [of my house] and have a drink, and I do the "don't forget yourself dude. Don't forget the things that make you, you." *(6.14)*

As illustrated in these quotes, reflection gave rise to awareness of the strengths and potential that existed outside the high-risk "bubble" that they previously inhabited. Comments such as "don't forget the things that make you, you" were critical to the realisation that there were fundamental things about them that existed outside the context of the collective. These reflective features may be understood to have enabled adaptation towards a future that incorporated physical, psychological, and social change.

In the early stages of rehabilitation, when participants could no longer do what they once did, could not contribute in the way they knew how, and where previous ways of "pushing" no longer served them, they were forced to look inward and reflect on their changed self in order to adapt. Initially, this process of reflection on self included themes of what it meant to become someone they had prided themselves on not being, such as those with vulnerabilities.

> I always had a view of posttraumatic stress disorder as being fake and people just made it up to get out of work or whatever, and I was pretty hard on people when they went that route. And then when I went that route, … it didn't help much. *(6.15)*

Vulnerability, embarrassment, and becoming someone they prided themselves on not being may be usefully understood as an experience of humiliation, prompted for many by the degree

of dependence they came to experience. This included an extreme inability to attend to the most basic needs or daily tasks.

> I know what it's like to sit there all day and not have anybody to speak to, except a nurse and an occasional visitor. … I understand the reality of it. I know all the bad parts of being broken. To s**t yourself. You can't even wipe your own arse. To be dependent on somebody else. *(6.16)*
>
> …because of all these medications, I need constant supervision. My wife does them [because] … I can get confused and take the wrong ones at the wrong time. … I will leave the stove on and stuff like that. *(6.17)*

Conceptually, the level of dependence that required others to both supervise and attend to their intimate needs may be considered akin to that experienced as a child. For those who were successfully adapting to their changed self, the extreme dependence and associated humiliation appeared to give rise to a new-found humility they later came to value.

6.6.1.1 Humility

For this group of previously proud and valued individuals, gaining humility involved the creation of perspective wherein they stepped out of their immediate context (previously described as a "bubble") to view themselves within a bigger picture. This perspective enabled them to reflect on the way they thought about themselves and their situation: "[I think to myself] 'you've got nothing to complain about. Nothing at all. Keep it real. Look at yourself in the mirror and keep it f**king real.'" For many, a process of downward comparison with those they considered 'worse off' was associated with a move towards acceptance of their own current limitations:

> I am still here and I am still breathing, and my life goes on. And my life is better than theirs [deceased colleagues] because they are not here anymore. There is always someone worse off than you. … I think about the mates who I have worked with, who have died, and I think [of] the things they're missing out on and things their families don't have. They don't have *them* anymore. I don't think "shit, I can't do this or that properly", it's like that's nothing. They have lost their husband or their father. *(6.18)*
>
> You look at other people that suffer and it's like, "why should I worry about myself?" you know?" You feel disrespectful to think that what I am going through is worse than what someone else is going through. *(6.19)*

Humility also grew from humiliation when they came to accept their situation, to find new ways to cope. Acceptance was heavily intertwined with talk of contrast and perspective, illustrated thus:

> … s**t happens. Good and bad. There is no point dwelling on what was happening before and what could have happened. That will get you nowhere. It

> has happened. Deal with it and just keep going, … it's not the end of the world. It doesn't stop you from breathing. *(6.20)*
>
> … to me and I think for a lot of guys, it is perspective and contrast … from either what they have seen, done or what has happened to their mates, I think it is a constant evolution. It is a constant evolution of coping strategies. *(6.21)*

This process of gaining perspective and acceptance enabled some participants to see the value in life itself, as exemplified in comments such as 6.20 and "I am still here and I am still breathing."

6.6.2 Stage 2: Build and repair relationships with others

As discussed above, self-awareness became necessary when participants' habitual mode of overcoming obstacles (pushing) was recognised as ineffective, a process which involved humility. Self-awareness also stimulated a greater awareness and appreciation of others, expressed through the values of compassion and gratitude. Collectively, humility, compassion and gratitude helped participants to connect with those they could previously not identify with, and repair relationships with those they had taken for granted.

6.6.2.1 Compassion

Prior to their wounds, injury, or illnesses, participants came to value themselves and others in their cohort, specifically in relation to their capability and strength which enabled personal and collective survival. The humbling experience of wounding, injury, or illness forced them to observe life from a different perspective. This perspective was that of relative vulnerability and dependence, a feature some noted as inherent to other populations, including those previously impacted by wounding, injury, or illness within their own unit. This shift in perspective enabled participants to develop a sense of increased compassion and concern for others.

> I think [before wounding] I was probably a bit s**t in the sense that I probably expected people to "Harden the f**k-up" which is probably the easiest way, you know? "You've broken your leg, and taken two years to get back to work. Get over it mate. Get your head-state right and move on." Well, the realities of life, that's not the case. The injuries are more complex than first seen. So I understand that a bit. I have more compassion for people. *(6.22)*

The ability to understand others and relate to them from a compassionate standpoint seemed to develop from an actual or imagined, shared emotional experience in which distance or boundaries between the self and vulnerable others were minimised. This affective resonance, or empathy, was interpreted positively because it increased participants' ability to relate to a greater range of people.

> You do become quite compassionate and you do become very emotional. [after serious injury] . … I was at a wedding and I was openly upset and I was crying, … not because the wedding was sad, it was because two days before, three guys died in a vehicle crash [during operations], and it was the anniversary of the crash. … The boys aren't going to be able to marry their girlfriends, so that's what upset me. So you develop a sense of compassion. *(6.23)*

> It [rehabilitation] has probably made me more understanding. … I can relate to them [my unit peers] and understand that they may have issues. … I can relate to them, and I can understand, and I can be empathetic. *(6.24)*

> Because I understand the frustration, … I feel like I connect with guys better, I suppose, and that's possibly because I am coming from a position of strength, where I have been injured. … I have been through this. I have seen it all. I get it. *(6.25)*

It appears that an inability to perform in their previous role, and the inadequacy of "pushing" in resolving the challenges before them, required participants to find new ways of coping. Those who turned inward, either by themselves or with the assistance of others, often came to realise the values of humility and compassion and these propelled them toward a paradoxical "position of strength." This strength stemmed through the ability to discern and minimise boundaries as they related to others, rather than the ability to push up, against or through them. With their new ability to understand and relate to others, many participants were also challenged as they encountered and negotiated feelings of guilt and gratitude.

6.6.2.2 Gratitude

Just as feelings of humiliation preceded humility in this population, guilt preceded gratitude. Many participants expressed personal guilt in relation to harshness they previously directed towards others in their unit, expressed above as "I probably expected people to 'Harden the f**k-up'", "before, I didn't understand them." For some, this harshness also related to those in the wider community:

> It was a little confronting. … I felt really guilty about any sort of thoughts I had in my head over the years, as to why we have to do so much work to accommodate people with disabilities, and ramps, and crap everywhere, … you know, when I was immature and later in life. *(6.26)*

Confronting this guilt was associated with acknowledging the co-existence of strengths and vulnerabilities in both themselves and others. This was linked to gaining a more mature, more sensitive, and more compassionate self. Stemming from this maturity, participants talked about the gratitude they came to hold for those they relied upon both prior to and during rehabilitation, such as family, friends, and the care workers who attended to their intimate needs.

> When you are thinking that things are really crappy just now, and a nurse walks into the room, she is really happy and positive and she helps you out. She's wiping your butt. You are doing a s**t. She is happy and she is helping you, and she's so happy that you were just able to do a bowel movement. … It puts your faith back into people. Because you know, here she is, she's done something great for you. It's such a small thing in the big scheme of things, but she is happy about wiping your arse, she [is] happy that you went to the toilet, she's happy just to help you. That puts your faith back into humanity. *(6.27)*

In the context of a high-risk combat unit, the increased ability of participants to relate to others, as in some way similar to themselves, and appreciate others as having both strengths and vulnerabilities, arose from the values of humility, compassion, and gratitude. These values enabled them to see the good, the value, and the potential in others, and in doing so, reinforced these within themselves, as demonstrated below.

6.6.3 Stage 3: Individuation and separation

After looking inward and turning their new knowledge (by way of self-awareness) toward others, some participants gradually developed ideas about how they might again contribute and be of value to their unit or broader society. At this point, those who aimed and were able to return to their unit, and those who found direction outside of it, were able to shift their focus away from others and back toward themselves in relation to an imagined future. This shift did not negate their gains in relation to others, but rather demonstrated an increased level of complexity wherein a new balance and congruence was struck between themselves and others. This rebalancing was symbolised in a moment of choice, followed by hard work characterised as personal integrity and responsibility, along with passion and perseverance.

6.6.3.1 Direction and moment of choice

Those who reported finding a sense of personal direction suggested that it manifested as a *moment of choice*, which participants articulated as a time at which they took back control of their lives—when they recognised the need for, and moved towards, change. This represented a cross-road that incorporated an expanded past experience, acceptance of present capability, and imagined future goals that included what they wanted, and what they did not want to be—a victim.

> As soon as I made that decision "nuh, no more" things started changing, … things changed in general, and not just with medication and that, but everyone's perception of me, and my perception of what was going on, and things like that I'm pretty much on this ramp now where I am getting better and better and better every single session. *(6.28)*

> I could just see myself in a mental hospital as a s**t thrower. … and I was like "No! The kids don't deserve to see that…," so … I just set about applying myself to get back to normal, but that was the realisation point as well, because I had to

> make a decision from that point, that … a change needed to occur, and I needed to have control rather than fumbling along. So I opted at that point, for control. *(6.29)*

> I made a choice one day. I was at the rehab[ilitation] centre and I'm like "I'm sick of this joint, it's full of victims. It's a poisonous atmosphere. I want to get out of here." and I started training back down at the unit, and that's the way I think people perceive me. I'm in there training, I've been wounded, I have been banged up and people come in and are like "oh s**t!" and give you a nod. It is what keeps me going. *(6.30)*

Some spoke of this choice as an emotional and cognitive moment, akin to an epiphany, that represented a shift from reflective adaptation toward action. Their speech also suggested a realisation that responsibility for the self, at that point, became internalised. Previously these individuals had taken direction from, and aligned themselves to, collective goals, and pushed themselves to meet them. The wounding, injury, or illness separated most from those goals, forced them from collective direction and compelled them toward their own. This occurred upon the realisation that pushing had become an ineffective means of adaptation and what required was acceptance rather than resistance. This moment of choice was more evident in those undergoing rehabilitation primarily for physical rather than psychological wounds, injuries, and illnesses.

6.6.3.2 Hard work

The personal direction that manifested in a moment of choice highlighted an individual who was both a member of the unit with a unique past, and who had a unique future to forge. This direction involved a shift from reflective adaptation to the more familiar value of hard work, characterised by personal integrity and responsibility, along with passion and perseverance. Most participants, regardless of their degree of gained personal direction, valued personal integrity and responsibility in both their active combat role, and rehabilitation:

> [I] have integrity in everything I do, … it might sound moralistic to you, but, you know, I take pride in that. *(6.31)*

> You don't choose the situation that has happened to you. Whether you have been shot, blown-up, twisted an ankle, whether you broke a leg in training. It doesn't matter. You didn't necessarily choose to be in that situation … but you have to acknowledge you are in that situation and you need to make steps for yourself to get out of that situation. You can't rely on someone else to recognise you are in that situation and pull you out of it. *(6.32)*

The value of personal integrity and responsibility underscored a renewed momentum for participants sustained through passion (an emotional state) and perseverance (a rational one). This produced a quality that enabled participants to once again "push" through their rehabilitation, albeit as more complex individuals. Specifically, passion was expressed

through the identification of *what*, and *who,* mattered (that is, what they truly valued), and were thereby worth fighting for. Perseverance was expressed as what it took to do it.

> I'm passionate about guys that are going through this currently. Trying to get the best processes we can for their outcomes, you know, moving forward. *(6.33)*
>
> I walked away with a sense of purpose. I'm like "your job is awesome! Fight for it" *(6.34)*
>
> I want to come back fighting. … It's honour. To honour the bloke that was killed, because I know that's what he would do. But I want to do it too. [But] it's not just for him, it's for me. So it's me, because that [focus on him] can only last so long. *(6.35)*
>
> Obviously, you have got to persevere. Rehab is not easy. It is boring, it is tedious, and it can be very frustrating, … the only option is to push through it all and succeed. … to … go "it's too hard", we don't do that. That's just not an option. *(6.36)*

The above statement "I'm passionate about guys that are going through this currently" demonstrates the participant's understanding that there were others likely suffering as individuals within the collective, with whom he could identify and help, in ways that others could not. In addition, the talk of being "passionate" and "fighting" not only for the self but for others, along with the statement "*we* don't do that", highlights the re-identification with the collective, and re-direction of values to rehabilitation. This re-identification and re-direction demonstrates a strong relationship between values and motivation in this population.

As previously noted, the shift from focusing on others and back to the self was not binary. Instead it demonstrated an increased level of complexity in the form of a self that was different from, but related to, that which existed earlier. The connection here was clearly that of values. Although the ways in which values were realised were different, participants seemed to find their way to a new self through recognising the values that underpinned their emotions and behaviours, by way of self-awareness.

6.6.4 Stage 4: Contribution

All participants once contributed as a powerful person to a powerful collective and this was the basis of their former identity or sense of self. The need for them to adapt to their wounds, injuries, and illnesses served to strengthen many participants' relationships with a wider range of people, and helped them create individual perspective. This perspective helped some gain direction wherein they worked hard to achieve new goals and, in doing so, many spoke about a new-found maturity, that saw them as a useful resource.

> I still have the same drive, but I have probably matured a bit through the whole thing. … It's taken a while for that to hit me though. *(6.37)*

Participants also observed that their peers seemed to recognise their maturity, and were drawn to it. This saw some participants finding a new source of relevance that gave them purpose, and provided a valued function that enabled them to take up new roles of service.

> Since I was injured, there are a few people in my work, who I know [that] have some mental health issues. I don't know whether it happened from the last deployment or if it has bottled up over time. ... and people do approach me. I don't know whether they think I've been through that path, or I have overcome it, or whatever, but they approach me, and I suppose I am - to my mates, boys in the unit - more empathic to them. Understanding. … It's weird. Like some people aren't even my really good mates, but they will tell me their darkest sort of secrets about what is going on inside. *(6.38)*

The importance of reflecting as a means of gaining acceptance and perspective (and thereby self-awareness) is demonstrated in the above passage by the participant's willingness to help others through acting as a *source* of reflection. It is likely the people referenced by this participant recognised the *sameness* in him, but also *difference* by way of maturity. Extending from this, new experiences of vulnerability, combined with other experiences of strength, enabled some participants to do new and valuable things, directly within and outside of their units. These activities included contributing to highly contextual and sensitive matters that required a degree of authenticity, of genuine understanding and compassion that would be difficult to replicate in those who did not share their experiences and maturity.

> It's important to me, [in relation to] some of the guys who died, that I maintain contact with their families, because I really like them, and I feel I help them. While they're hurting—and they're still hurting, they will probably always be hurting … that's really important to me. And to be honest, that's for my own wellbeing as well. So I make myself available to help out on those sort of things. *(6.39)*

> … then I got the call about Smithy [a peer killed in action], and they sent me in as the LO [Liaison Officer] for Smithy's family, and those … things to help bridge that gap again. Kept me around the unit. Gave me a feeling of being …

> important again, and being able to help the boys, and you know, whatever matters. *(6.40)*

These forms of contribution, that served to build relationships and connect, provided a pivotal role to both the unit and the broader community. They also brought benefits to the participant: "[it's] for my own wellbeing" and "[it] gave me a feeling of being … important," and in doing so, consolidated their past and present, possibly helping them to gain confidence and direction for their future. Such contributions also provided a sense of renewed identity, in part, through agency, because they were able to help others in a way few others could.

6.6.5 Stagnation

Despite the ability of some participants to adapt to their changed state, and achieve separation from the collective, others found adaptation difficult. This was particularly evident for the two participants who were recovering primarily from mental health conditions. These individuals appeared to have difficulty with reflecting, and so seemed to become stuck, apparently encountering a boundary that could not be pushed passed (i.e. lost function). It seems likely that it was the mental health impairments themselves that precluded or at least drastically reduced the capacity to engage in this process of reflection that appeared so seminal in the successful adaptation of their peers, enabling them to accept their situation, gain perspective, to find their potential value, and direction. Ultimately, this made it difficult for these participants to resolve feelings of humiliation and guilt, with one participant resorting to "hiding behind bushes" and the other choosing to "cut all ties [with the unit]", lest they be seen in a diminished state. A participant who talked about his extreme psychological suffering, explained the motivation for his behaviour thus:

> [It's] guilt, shame, embarrassment. … It's not really wanting to put myself out there, to allow the risk of disappointment to happen, because it would take only one, one person … [to] destabilise you. *(6.41)*

For this participant, what underpinned his behaviours and emotions appeared to relate to his perception and anticipation of the thoughts, intentions, and judgements of others. This focus on others, which may be construed as the over-valuing of them in relation to the self, also impacted basic motivation:

> **Interviewer:** What does it take for you to do stuff?
>
> **Participant:** Usually being prompted by someone.
>
> **Interviewer:** Being prompted by someone will get you going, but what is the motivation behind going?
>
> **Participant:** Not wanting to let them down.
>
> **Interviewer:** Let who down?

> **Participant:** Whoever prompted me. *(6.42)*

For these participants, lost personal motivation, perhaps observed behaviourally through lost perseverance, also related to confused or lost awareness of what they valued or how they could be of value. The above participant, as a case in point, at another time in the interview, indicated that he understood health in relation to his function within the collective (perhaps because he felt valued in it), but not in relation to himself, outside that context.

> **Interviewer:** Can you tell me, from a physical health perspective, what it means to be healthy…?
>
> **Participant:** I don't know any more ...
>
> **Interviewer:** When you were … operational, what did it take to be physically healthy?
>
> **Participant:** Lots of training … training for war. For me, as a specialist, lots of heavy pack marching.
>
> **Interviewer:** … Do you have an idea of what health means to you now? Physical health?
>
> **Participant:** I don't know. *(6.43)*

The suffering of this participant, and others like him, may have been exacerbated by the current knowledge of the former self, along with an inability to access to that which facilitated the enactment of the values inherent to it—whether such values were related to the lost role, lost personal capacity, lost others, or all of these. The two preceding excerpts also point to the impact a lost sense of personal identity had on motivation. In addition, they highlight the extent to which this participant potentially over-valued others' thoughts and opinions, relative to his own.

One plausible consequence of this inability of these participants to draw on their personal identity and agency was that these participants remained stuck in humiliation and guilt, the resolution of which was necessary for others to find a new balance between themselves and others. Humiliation and guilt were perhaps a consequence or means of personal devaluation and thereby overvaluation of others—perhaps an extreme version of the selflessness necessary for service wherein the task and the team ultimately take precedence. Accordingly, these participants found it difficult to envisage any other way of being in the future, other than what they had been (which they were aware was unlikely):

> They [anger, mood and lack of patience] probably got worse and worse… probably a loss of confidence, I suppose, as well, … more in myself. Just in my ability to go out there and get another job and succeed at it. *(6.44)*

> I am in a bit of a void at the moment. With all these treatments, and I have to come to terms with the fact I am not going to be a specialist again. … I am not sure what else to do. *(6.45)*
>
> **Interviewer:** How do you see yourself in the future …?
> **Participant:** I don't really know to be honest. That's the golden question, I suppose. Yeah, I am probably lacking a fair bit of direction. *(6.46)*

The issues highlighted here suggest that a lost sense of self in those with psychological conditions precluded many of the gains realised by others, or at least a realisation of those gains. As a result these participants continued to struggle with humiliation and guilt, along with a lost sense of motivation and confidence: combined, these negatively impacted their ideas about how they might contribute (and thereby be valued) in the future.

6.7 Discussion

The aim of this study was to examine the relationships between values, behaviour, and adaptation to serious wounds, injuries, and illnesses for high-risk combat personnel in the Australian Army. Results indicate that those with physical changes adapted differently to these experiences than did those with psychological changes.

For those with physical limitations, five sets of values underscored four sequential stages of adaptation that helped participants adapt to change and overcome ensuing feelings of humiliation and guilt. The five sets of values were: humility, compassion, gratitude, the identification of personal values and hard work, and maturity.

The first stage involved a shift from pushing (as a means of adaptation) to reflecting. This helped participants accept their circumstances and gain perspective of themselves, in relation to others. Reflection, acceptance, and perspective were all associated with humility and specifically helped overcome feelings of humiliation. The second stage of adaptation involved building relationships with those they could previously not relate to, and repairing relationships with those described as taken for granted (such as individuals who supported them prior to their wounds, injuries, or illnesses, and during rehabilitation from it). Building and repairing relationships was associated with compassion and gratitude, the latter of which specifically helped to mitigate feelings of guilt. During the third stage, participants gained a degree of individuation through their recognition of their strengths, which enabled them (to some degree) to psychologically separate from (but not necessarily renounce) the collective. This shift was experienced as a moment of choice, rapidly followed by endorsement of the value of hard work, further characterised by integrity and responsibility, as well as passion and perseverance.

Although the ways in which values were enacted in their former military role were different to the ways they were enacted in rehabilitation and transition, participants seemed to find their way to a new self through the recognition that these values underpinned their emotions and behaviours. Finally, all participants spoke of their desire to contribute to the collective or broader society and for some, the ability to do this was aided by the maturity gained through rehabilitation, which was clearly valued by others. The process and stages of adaptation and their associated values are depicted in the model, presented as Figure 15, following.

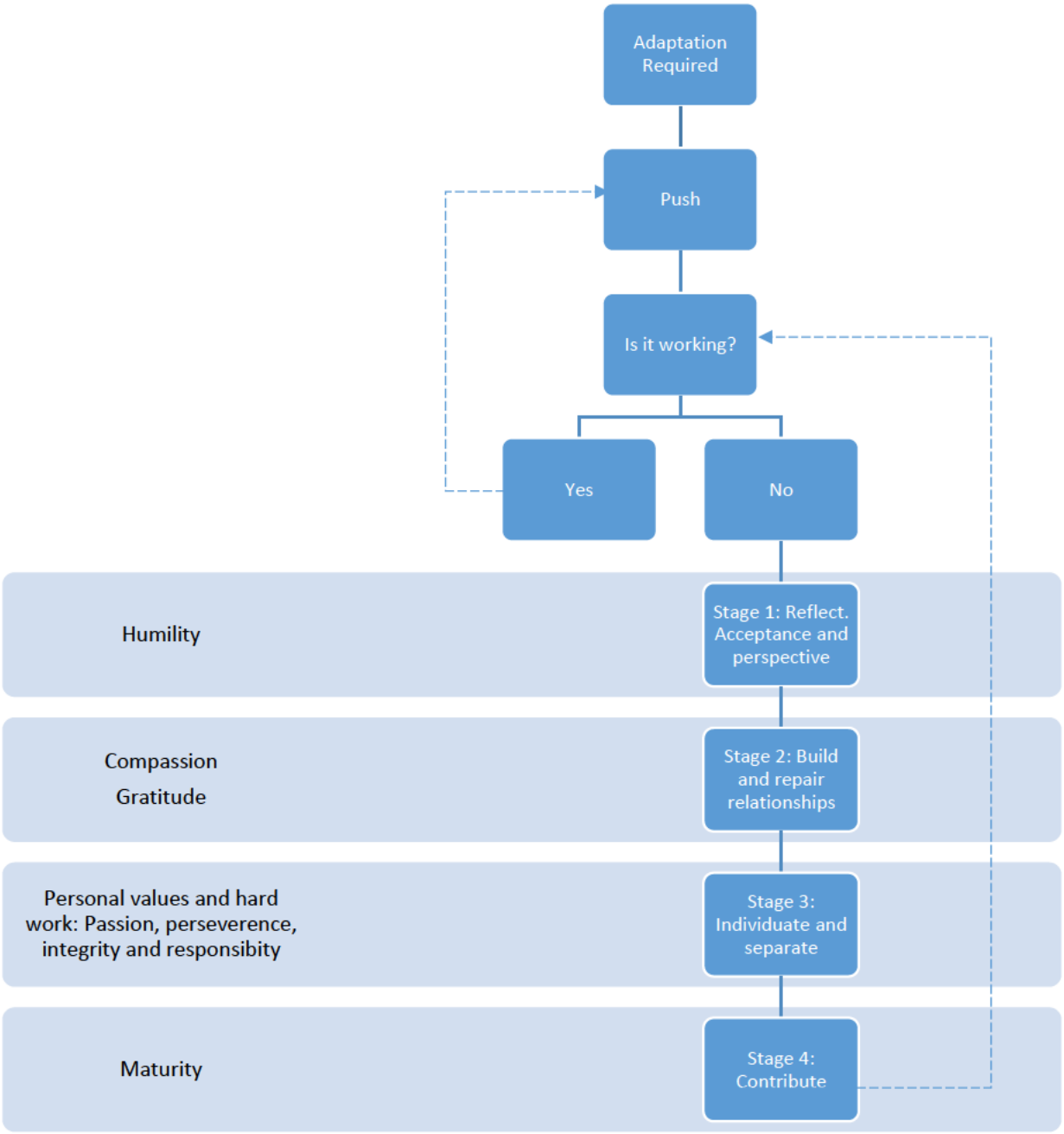


Figure 15. Flow diagram depicting the process of adaptation with psychosocial values on the left and adaptive stages on the right

As depicted in Figure 15, those with physical conditions went through a process of adaptation in four stages, each underpinned by specific values. Many of these values reflect those professed by the military and were therefore well known to them (see Figure 14). Using a developmental lens, these stages mirror the process of adolescence, when these tasks are integral to successful development and individuation, culminating optimally in a clear sense of identity: of who *I am* in relation to others. This is a process of self-other rebalancing (Blos, 1967; Guntrip, 1961; Kroger, 1996; Sugar, 2003; Mahler, 1974).

The task of gaining an individual identity as participants moved away from the quasi-familial collective (described by participants as a "brotherhood" (see quote 3.44) and elsewhere as fictive kinship (Woodward and Jenkings, 2011)) is not the only feature they shared with adolescents. The speech of participants suggests they also held a belief in their invincibility (e.g. see quote 6.9) prior to their rehabilitation experience, and tended to push boundaries (e.g. see quotes 5.2, 5.3, and 6.36). Chapter 5 of this study also highlight a degree of *all-or-nothing* thinking (which is characteristic of the teen years (Calhoun and Tedeschi, 1999; Leather, 2009; Stoep et al., 2009)—a feature noted in other military populations (Sugar, 2003, 2004; Van Der Kolk, 1985; Yerushalmi, 1997). For civilians, these behaviours and attitudes are considered a phase of development eventually outgrown (Leather, 2009); however, in this population, the same features were highly valued and cultivated, being a central feature of habitual adaptation to threat to person, and mission success. Lending further support to this assertion, one participant spontaneously offered the idea that his most adaptive features were akin to a "kid's revolt against their parents" (see quote *6.4*).

In a rehabilitation context, participants' feelings of invincibility, described behaviourally as pushing, were replaced by experiences of vulnerability and dependence. When pushing no longer served them, for those who reported progressing well in transition and rehabilitation, all-or-nothing mind-sets matured into a more complex way of viewing themselves and others. This suggests that the 'self' they once knew, previously described as largely defined by their ability to perform valuable tasks as a part of their team (e.g. see quote 5.6), was stripped away on wounding, injury, and illness. This constituted a loss of self, such that the task before them was akin to that of the adolescent: to develop and reconstitute a new self, which, once achieved, resulted in increased maturity. This understanding is commensurate with the views of developmental scholars who have posited that a degree of regression is often needed to spur the self-awareness necessary for a new beginning (Balint, 1979) or a more mature identity (Erikson, 1968; Kegan and Blos in Kroger, 1996). Psychosocial states associated with

adolescence, then, may be critical to high-risk combat roles but experienced as maladaptive outside of it. If this is so, then, rehabilitation and transition out of previous roles are positioned as critical periods for identity decline or development in this population. Such insight provides a useful frame as to what constitutes successful psychosocial rehabilitation and transition, and highlights the challenges for those who do this with psychological conditions.

This research has theoretical, clinical, and policy implications. First, transition from the military and other collective prosocial organisations to either a rehabilitation or civilian context (or both), may be usefully framed by developmental theory wherein a new balance must be struck between the self and others, as a conduit for individuation and separation (Kroger, 1996). This frame may help structure organisational rehabilitation and transition services, and research agendas that underpin these, in a way that may lead to better understanding of, monitoring, and support for those who experience distress during or after service.

Specifically, the process of self-other rebalancing may be supported both clinically and through community programmes. This is due to the fact that values are central to this model of adaptation, both in terms of shared values (that aid adaptation) and personal values (that provide direction), and because values are difficult to recall and verbalise (Bednarek-Gilland, 2015; O'Toole, 2016), therapeutic approaches might involve helping the individual to bring them to their own conscious awareness. Based on this analysis, clinical interventions for those suffering during rehabilitation or transition should account for the need of the individual as they adapt from the collective. These might include psychodynamic (Hendin, 2014, 2017) or existential approaches such as logotherapy and narrative therapy (Southwick et al., 2006; White, 2004; White, 2007). Under circumstances where group therapy is indicated, the *Skills Training in Affective and Interpersonal Regulation* (STAIR) program (Cloitre, Jackson, and Schmidt, 2016; Landes, Garovoy, and Burkman, 2013) also explores the self-other dimension and interpersonal readjustments. In the community, self-awareness may be forged by providing opportunities for subjectivity, creativity, and self-expression, as offered, for example, in artistic programmes (Nanda et al., 2010).

Finally, drawing on the notion that values are transferrable (that is, they apply trans-situationally and trans-personally), the final task of individuation and separation for those who successfully transition from the military may require a social response that capitalises upon the values inculcated in veterans, in a way that benefits both them and society. As

highlighted in this research, individuation and separation occurred when participants found a sense of direction, and for most, this occurred when they envisaged themselves filling a new and valued role: some found this role within their unit and others found it elsewhere. Either way, all participants in this study spoke as contribution as critical to them; relevant community programs may involve creating roles in which the strengths of individual veterans are matched with local councils and state governments to provide innovative solutions to social problems—including those inherent in the veteran community. Such initiatives might also see some ex-service organisations evolve from veterans helping veterans—to veterans helping veterans to help others. This may be especially useful for those whose identity remains anchored in a prosocial or service ideology.

6.8 Limitations

The results and analysis of this study were based on the rehabilitation and transition of 13 high-risk combat personnel. Although physical, psychological, and social decline were reported by most participants, only two were primarily diagnosed with mental health conditions. This small number may limit the extent to which findings may be applied to those primarily diagnosed with mental health conditions, however it does highlight the challenges they face. Further qualitative research that elucidates the experiences of those with mental health conditions, as they adapt to rehabilitation and transition from the military, is called for.

6.9 Conclusion

In the studied population, rehabilitation in the military and transition occurred in stages, each of which involved unique values that helped create self-awareness, build and repair relationships, and finally, individuate and separate from the organisation. This process was akin to the self-other rebalancing tasks of adolescence, and suggests that a developmental approach may be useful when considering the needs of those who struggle to adapt during rehabilitation or transition to civilian life. In addition, this insight may go some way in understanding the inequitable health outcomes veterans often experience, relative to civilians, many of which involve issues of identity. These include PTSD, anxiety and affective disorders, (McFarlane et al., 2011), isolation, homelessness (Bryan and Rudd, 2012; Goldstein et al., 2012), self-destructive behaviours (Hines et al., 2013; Maguen et al., 2011; Pietrzak et al., 2013), and suicidality (Australian Institute of Health and Welfare, 2017; Maguen et al., 2011; Parliament of Australia, 2017; Pompili et al., 2013). A developmental approach to rehabilitation and transition of veterans to the civil community may also provide a psychologically-informed theoretical foundation that can guide both service provision and a

research agenda to underpin it. Critically, this research and the theoretical understanding of the results also demand a social response wherein veterans come to be valued by society, not *despite* their service and experiences of wounds, injuries, and illnesses, but because of these.

Chapter 7. What does it all mean?

The primary research questions addressed in this dissertation aimed to determine how high-risk combat soldiers' identity is affected by serious wounding, illness, or injury, and how potential shifts in identity may impact on health and health-related behaviours. Results demonstrate that participants experienced significant identity loss during rehabilitation, which prompted a lost sense of belonging and a spiral of physical, psychological, and social decline. The conditions that preceded rehabilitation had an impact on this decline, and these conditions included strong affective bonds with their tasks and their teams, collective confidence and trust, and the value afforded to them when operating in their role. These states were sharply contrasted to the isolation, devaluation, and vulnerability that participants experienced in rehabilitation, which related to feelings of helplessness, anger, and lost motivation, as well as states of anxiety and depression. Some participants also experienced guilt, humiliation, and shame—features associated with self-destructive behaviours and suicidal ideation. These states, feelings, and behaviours were underscored by changes in participants' sense of identity and agency (sense of self) and further aggravated by the difficulty participants had in trusting and connecting with others, including clinicians. This "disconnect" impacted the felt capacity for many to seek help for distressing experiences prior to rehabilitation and for some, during it. This finding was not surprising because the concept of self is understood to be directly related to interpersonal functioning, including the capacity to connect with others (American Psychiatric Association, 2013). Problems with self, therefore, impact the potential for relationship and the potential to regain a sense of belonging.

Of those recovering from physical issues, some could arrest their pattern of decline and adapt to their changed state by first rebalancing the relationships that existed between themselves and others (re-connecting with others), and then undergoing individuation and separation from the collective. These processes of self-other rebalancing, and individuation and separation reflect core functions of personality as proposed by the American Psychiatric Association (2013): the development of self and interpersonal function. It is also a process normally associated with adolescence. The results of this study clearly point to rehabilitation and transition as periods of potentiality that may facilitate development of self and interpersonal function; however, it may also represent a window for decline.

7.1 Latent analysis using psychodynamic object relations theory

Various theories drawn from the fields of psychology, sociology, and neuroscience were used to focus and consider the results of this research. These included neuroscientific accounts of memory (Brewin, 2014), social and developmental psychology (Erikson, 1968; Kroger, 1996), flow (Csikszentmihalyi, 1990), liminality (Turner, 1979), Emotional Focussed Theory (Pascual-Leone et al., 2013), and values (Bednarek-Gilland, 2015; Schwartz, 2017). The Chapters 3 to 6 each highlight the important contribution each of these foci have made towards understanding and conveying specific phenomenon.

A psychodynamic object relations account of the findings is further offered for four reasons. First, many theories around transitions in and from the military tend to be reductionist (Shields et. al., 2016) with little account for the intrapsychic processes of the individual as they exist in a biopsychosocial context, both temporally and contextually. Second, object relations theory is primarily concerned with relationships. Themes of fractured relationship (i.e. loss, disconnection, loneliness, and feelings of isolation) feature strongly in this study (with their consequent health behaviours) and within the broader veteran community (see Brewin, 2011; Brunger, 2013; Shields et al., 2016). Third, the theoretical basis for object relations was largely developed and employed by practitioners who were both veterans and medical officers and who thus held insight into the impact of war on the individual. Finally, because a psychodynamic object relations approach has the capacity to form the basis of a unified and coherent latent analysis of chapters in this dissertation, which may otherwise not be possible (Braun and Clarke, 2006). To highlight the critical nature of such analysis, the words of Harry Guntrip (originally referenced in Chapter 1) are intentionally restated, to reinforce the importance of considering people in their entirety, as well as acknowledging their potential for relationship, by way of personal maturation:

> … every study of human beings, from any aspect whatsoever, should be kept well subordinated to the basic fact that, unlike all other organisms, it is mans' potentiality to become what we mean by a 'person', and his true destiny (whether fulfilled or not) is to mature an individual personality in the medium of personal relationships. One may study man from the physiological, biological, psychological or again from medical, social or religious angles. But all these studies get out of focus unless controlled by the over-all understanding of what a human being is in his total nature … That what is to be treated is not a disease entity but a patient who is a human person.
>
> (1961, pp. 38-39)

Object relations theory clearly positions relationships as the greatest capacity of humanity (Guntrip, 1961), of benefit to the individual and to society more broadly.

7.2 Normal processes of object relatedness and personal development

The quality of a person's relationships with others is heavily intertwined with the relationship they have with themselves. It is this relationship between self and others that is central to object relations theory. At this point, a brief reminder of normal object relatedness is presented.

An object, in psychodynamic terms, may be something or someone outside of the individual that holds meaning (Gomez, 1997), is identified with (through affect), and taken in as a part of one's own identity (Fairbairn, 1952; Gabbard, 2010; Gomez, 2017; Guntrip, 1961). In short, objects begin external to the self *out-there* and through affective identity formation (Spitz, 1965 cited in Modell, 1968), who (or what) is out-there comes to situate *in-here* as internal representations of the self (Gabbard, 2010; Sherwood and Cohen, 1994; Fairbairn, 1952; Modell, 1968). Identity formation begins with *connection and sameness* with others (Kroger, 1996; Modell, 1968), but a mature identity is understood to be characterised by the ability to perceive the self as *separate and different* from others (American Psychiatric Association, 2013). Although relationship remodelling may occur throughout life (i.e. balances between self and others are continually negotiated) (Erikson, 1968; Feeney, 2008), it is generally agreed that the first three years of life, and adolescence are the most sensitive periods of identity formation (Blos, 1967; Kroger, 1996; Mahler, 1974).

As highlighted in the current study, the military places enormous demands on the identity of high-risk combatants, first through the process of recruit training and later through the requirement to operate in dangerous and unstable conditions. Due to these demands, individuals were required, to an extent, to adapt their identity (especially by way of foregrounding of specific values) to operate in a culture that places tasks and teams above the individual.

This section highlights the specific intrapsychic mechanisms employed by participants as they adapted to combat and rehabilitation, and is based upon the results discussed in the previous chapters. Adaptive mechanisms (often referred to as defensive mechanisms) will first be explained in their broadest sense, and then more specifically in relation to participants' experiences. Having established what these adaptations involve, their potential impact on physical and mental health, along with help-seeking and health behaviours, are discussed. Finally, the strengths and values drawn upon by participants in rehabilitation will be

highlighted as a foundation for transition in this population and incorporated into the implications of the research.

7.3 Adaptations to combat and their consequences

7.3.1 Defence mechanisms as adaptive

In the face of trauma, primitive defence mechanisms are usually employed by the psyche to accommodate experiences that occur 'out-there' (in the environment), which in turn, protects the individual from being psychologically overwhelmed by them 'in-here' (in the mind) (Khan, 1963; Sherwood and Cohen, 1994; Van der Kolk et al., 1996). Indeed, any intrapsychic defence can be "adaptive or non-adaptive, depending on the consequences" (Kaplan and Saddock, 1991, p. 391), which implies that those adaptively employed in one context may be mal-adaptive in another. The consequence of adaptations to combat of those in this study was collective survival, and because of this, the term *primitive defence mechanisms* will be replaced with the term *adaptive mechanisms* for analysis. In addition, the term 'adaptive' rather than 'defensive' better reflects the willingness of participants to serve their nation in the capacity of combatants who *actively* exposed themselves to traumatic circumstances on an ongoing sustained basis. Participants' adaptions to trauma will be discussed below, the first and common adaptation being that of *dissociation* (Van der Kolk, 2014).

7.3.2 Dissociation and potentiality

Dissociation is normally understood to occur in the face of immense fear and trauma. It is a state that brings about changes in consciousness, and suspension of identity, that can leave an individual psychologically dis-integrated (Cardeña, 1994; Schimmenti and Caretti, 2016; Van der Kolk, 2014; Van der Kolk et al., 1996), or perhaps dis-organised.

Participants described early combat in ways that reflect disassociation, prompted by extreme fear and trauma, to the extent that some were unable to recall specific experiences. Upon repeated exposure, however, combat was ultimately remembered and described as a state of flow which not only protected against feelings of vulnerability, but increased integration of capacity and sense of agency. Flow was experienced by participants as a strong sense of merging with the task and the team, which was a state described not only as "good" (see quote 3.30) but also as a euphoric state of belonging. Merging has similarly been described in the psychoanalytic literature as prompting feelings of "religious ecstasy" (Modell, 1968 p. 37).

When discussing combat, participants described the merged state of flow as always *preceded* by feelings of fear (see Chapter 3), which suggests that fear may have activated early

attachment needs (Ainsworth, 1985; Bowlby, 1973; Cassidy and Shaver, 2008; Kernberng 1984 in Salande and Perkins, 2011), and conversely, that flow provided the sense of security and safety that relieved fear. The idea that flow relieves anxiety or fear has been observed in other role and performance-based populations (Kirchner, 2008; Thomson and Jaque, 2012) as well as those involved in extreme ritual (Lee et al., 2016). This relationship between fear and flow suggests that dissociation may represent a potential space (Winncott in Ogden, 2014) for identity development or decline. On one hand, identity may be gained if the threat that causes anxiety or fear is mastered through fusion or merging with the task and team, but on the other hand, if the threat prevails, identity decline or dis-integration may result.

Although identity can be gained in combat through merging with what feels safe, secure, and powerful (i.e. the task and the team), it is, nonetheless, a suspended state that aids survival and from which an individual must eventually redevelop or re-emerge as an integrated whole. This task becomes pressing when the context of the individual changes or when threat to safety and survival subsides. In the studied population, and for many that face fear on an ongoing and sustained basis (such as police and other emergency personnel), the process of re-developing and re-emerging as an integrated whole may be problematic.

This is because merging with that which is good, powerful, and safe, from a state of dissociation, also involves separation from parts of the self that feel bad or vulnerable (Kernberg,1967 in Blass, 2015; Modell, 1968). These bad features were likely first represented in others by way of the enemy (see quote 3.5), in which case vulnerability, flaws, and limitations were symbolically linked to them. As participants did not identify with the enemy (an extremely adaptive attribute), it became increasingly likely that they could not identify with these features in themselves. This process, as a by-product of dissociation, is commonly referred to as *splitting* (Modell, 1968).

7.3.2.1 Splitting and further adaptations

Splitting is a phenomenon associated with normal and abnormal development of the mind. Normal splitting is necessary as it helps organise experiences and objects of the external world “into benign and persecutory categories” (Rosenfeld and Klein in Gomez 2017, p. 64). When objects are internalised as self-representations, splitting further helps prevent diffusion of anxiety across these divisions (Kernberg, 1967 in Blass, 2015), thus forming the foundation of schematic psychological organisation. In healthy individuals (or normal development), these divisions are made yet remain symbolically linked, so they may be reconnected when demands for adaptation are made (Bion in Gomez, 2017 p. 48-49).

When splitting develops abnormally, as often occurs in the face of trauma, perceptions of others may shift to all good and all bad categories and extremes (Kaplan and Saddock 1991; Klein 1952, in Gomez 2017, p. 22), which further develop as self-representations. Splitting can be experienced collectively or individually. It can further be internalised or projected onto others, or all these. A basis mechanism and consequence of collective splitting was described by Salande and Perkins as:

> a function of how an individual views the group he or she is part of, and that group's relationship to the outside world. Thus, by virtue of being part of the "good" group, one is made "all good" and is thereby in serious conflict with the outside world, which is, of course, "all bad."
>
> (2011, pp. 386-387)

Either way, abnormal splitting (even that which occurs as adaptive in context) is understood to be an attack on the process of linking or connecting in the mind, and can "protect against pain by destroying all meaning and interconnectedness of thought, feeling and action" (Bion, 1959 in Prior, 2004). Once split in this way, the mind employs further adaptations to ensure this level of organisation is maintained, some of which are evident in the experiences of participants in this study. These adaptations include *omnipotence, devaluation, idealisation,* and *denial* (Klein and Kernberg in Summers, 2014); critically, although they serve survival and mission success in context, these features can render a person's inner life as incomplete, and thereby increasingly fragile.

7.3.2.2 Omnipotence, devaluation, idealisation, and denial

Although participants talked about personal fear in combat, their overall talk of themselves and their team was clearly linked to a sense of omnipotence, which in turn, increased personal and collective confidence (see Chapters 3 and 4)—features critical for those who operate in dangerous and unstable conditions. Some psychodynamic theorists have stated that omnipotence is related to feeling in "absolute control" (Klein, 1940 in Summers, 2014 p. 91), but this research suggests it was experienced as having the absolute ability to exercise control in dangerous and unstable environments. Regardless, omnipotence is associated with the renunciation of some psychic reality (Klein, 1940 in Summers, 2014) needed to effectively operate in civil society, which necessarily involves a degree of having some control *and* some vulnerability.

One problem with developing a sense of omnipotence is that the exposure of limitations and flaws that occur upon wounds, injuries, or illnesses can leave individuals or teams feeling vulnerable (Van der Kolk, 1985). In this study, such exposure occurred simultaneously with a

sense of extreme devaluation. Devaluation occurred from the perspective of the army, by way of a medical "downgrade," which was internalized at the individual level (i.e. "and now, I'm like, at the bottom, … for me, it's disgusting"). This dual devaluation from others and the self, which occurred at a time of heightened vulnerability, had a very powerful and negative impact on identity, which in turn impacted the health behaviours of participants (see Chapter 5 with further elucidation in sections 7.36, 7.37, and 7.5).

Whilst omnipotence and devaluation are born of splitting, idealisation (or overvaluation) of others and denial of the self may be understood as mechanisms of the mind that maintain the split (Kernberg, 1975, in Summers, 2014). Denial has been described as "a disregard for entire areas of subjective experience" or as a total denial or disregard for the self (Kernberg,1975 in Summers, p. 203). Evidence of denial within this population is presented in Chapter 3 as a highly adaptive redirection of focus and awareness away from the self, and toward the task and team—both of which were necessarily valued over the individual. This denial of self and overvaluation of others supported the external focus that enabled continued movement toward danger, despite the conscious and physiological register of threat. Other scholars have noted the phenomenon thus:

> … their bodies register the threat, but their conscious mind goes on as if nothing happened [or could be about to happen]. … even though the mind learns to ignore the messages from the emotional brain, the alarm signals don't stop.
>
> Van der Kolk (2014, p. 46)

Subjugation of the self and focus on the task enabled participants to accept fear, and even enjoy it. The comment from Chapter 3 "... you are as scared as you can probably imagine. [it's like] if you [are] just about to see a car head on to you, but you are still enjoying it" exemplifies the utility of denial in this population, positioning it as the adaptive mechanism that underpins such selflessness, observed behaviourally as courage.

Paradoxically, it was the denial of personal selfhood and subjectivity, and increasing externalisation toward the task and the team, that strengthened collective identity, and simultaneously undermined the personal identity of many participants. Lost subjectivity along with a growing aversion to all that was vulnerable, limited, and flawed (in both themselves and others) were undoubtedly adaptations that enabled selfless courage in combat. However, although participants found it increasingly difficult to connect with these parts of the self and others, they were still required to live and work in non-combative environments (such as rehabilitation and civil society) that demanded tolerance of such imperfections. Living and

working in such environments likely brought about a diffusion of anxiety between the split parts of self which threatened to psychologically overwhelm the individual. Because of its potential to overwhelm the individual, splitting is associated with mental and physical health consequences.

7.2.3 The physical health consequences of splitting

The physical health consequences of splitting may be understood in terms of chronic health problems, exacerbated by healthcare avoidance and self-destructive behaviours. This section will briefly address chronic health issues as they relate to splitting in combat. Healthcare avoidance and self-destructive behaviours will be addressed in sections 7.3.5 and 7.3.6 respectively.

As mentioned previously, veterans have poor health outcomes compared to civilians. Physically, many of these conditions are chronic, and include joint complications (e.g. pain, loss of mobility and arthritis), cardiovascular disease, and obesity (Department of Veterans' Affairs, 2017; Hoerster et al., 2012; Ministry of Defence, 2017a; Thompson et al., 2014a). These conditions have all been associated with allostatic load, which accounts for the cost of repeated physiological adaptations to stress, on overall health (Chapter 3) (McEwen et al., 2012; Schnurr and Green, 2004). It has been argued therefore that

> … elevated heart rate or cortisol may be needed in the short-term to help us adapt. Allostatic load takes into consideration the long-term cost of repeated stress and wear-and-tear on the body and brain. This leads to pathology and chronic illness. For example, changes in brain reactivity and increased production of stress hormones (called biological mediators) may have negative physical, psychological, and social health implications (Fava et al., 2010).
>
> McEwen et al. (2012, pp. 8-9)

Chapter 3 and section 7.35 document the way denial serves to override physical alarm systems that signal danger. These signals alert the individual to threat, but in this population (and likely for others who move toward danger when others flee from it, i.e. police, ambulance, and firefighters), the required focus on the task and team demanded that the threat to self be ignored to achieve mission success. Therefore, repeated, ongoing, and sustained denial (observed as selflessness and courage) and allostatic load are likely inextricably entwined, rendering those in courage-based professions as increasingly vulnerable to chronic health outcomes.

7.2.4 The mental health consequences of splitting

In addition to elevated levels of chronic physical health conditions, veterans are also susceptible to various mental health conditions, compared to civilians, especially in terms of

PTSD and other anxiety and mood disorders such depression (Department of Veterans' Affairs, 2017; Hoerster et al., 2012; McFarlane et. al., 2011; Ministry of Defence, 2017a; Thompson et al., 2014a). A psychodynamic object relations account of these disorders will now be offered as they relate to the splitting (i.e. adaptations that lead to feelings of omnipotence, devaluation, idealization, and denial) highlighted in this study.

With potential psychic splits in place, moving from a position of omnipotence to that of devaluation was clearly marked with the experience of distressing emotions for participants. For some, the distress was manifested as self-loathing and behaviours oriented toward self-destruction or annihilation. For some, once splitting was established in the mind, it was maintained through processes of self-denial and the over-valuation (or idealisation) of others, such as those in their unit or team. Whilst adaptive in context, the intrapsychic adaptations of splitting, omnipotence, devaluation, denial, and idealisation, were clearly marks of dysfunction outside the operational environment. Elsewhere, the reported psychological consequences of these adaptations have been proposed as "chronic diffuse anxiety [and]; polysymptomatic neurosis" that a weakened ego (or self) lacks the ability to manage (Kernberg in Summers, 2014, p. 201). In the current research, participants talked openly about combat giving rise to a diminished personal identity (i.e. by way of combat addiction) with at least one participant anticipating the difficulties of increased externalisation of identity (i.e. dependence on the task and the team), upon discharge thus:

> … they [civilian performers] get this big rush from being in front of a crowd, and being a big stage, and then when they retire and finish up, they can't fill that gap and they can't find that adrenaline rush again. That's the same I think with soldiers. I love my job and I thoroughly enjoyed doing what I did overseas and it is going to be hard to fill that, … transitioning … when that day does come to transition, it will be difficult. *(3.45)*

So far, it has been established that both the task and team were valued over the individual (by the individual) and that this relationship between the individual, their task, and their team, was underscored by strong affectionate bonds:

> You have a bond that is totally different to any other bond … I just know, it's a different type of relationship to every other type of relationship I've ever had. And the biggest thing that drives it is that you don't want to let them down, and they don't want to let you down … you would happily put yourself at risk to keep them out of risk, type of thing. *(5.7)*

Some participants went so far as to label these bonds with their task and their team, as love, akin to that more typically experienced in the context of a family:

> It was heart-breaking. I had worked so long and so hard to do it. And having loved the job so much, and most importantly, working with the boys … *(5.16)*

> These guys are like, brothers by choice. You love these guys with man love, and you love this [biological family members] as in real love. So you care about the welfare of both groups. *(3.43)*

These bonds place those in the primary unit as akin to siblings, and the military in a quasi-parental role. Indeed, it is the parent in a primary family group, as well as a military one, that provides direction, sets standards, and who operates as the authority figure whose approval (either implicit or explicit) must be gained. These strong familial bonds of love, based on the need for survival, likely set the scene for the anger and depression many participants felt in rehabilitation and transition (described in Chapter 5). This may be because while participants exemplified the standard and thereby image of the ideal soldier—"fairly smart," "fit," "strong," "no injuries," and "uncompromising in their willingness to do what it takes to get the job done" (see quote *6.2*)—they felt individually and collectively valued. However, when the individual no longer exemplified this standard, they were devalued or "downgraded" (see quote *5.14*) and forced to separate from the bonded unit or team. Whilst practical in its outcome, current theory surrounding military rehabilitation and transition does not account for the affective consequences, such as the anger and depression observed in this and similar populations (Bursnall et al, 2001).

From an object relations perspective, anger or hate may be understood as frustrated love: "the object one hates is the object one seeks satisfaction from but finds frustration in" and therefore "the opposite of love is not hate but indifference" (paraphrase of Guntrip in Summers, 2014, p. 56). Because anger is frustrated love, after being devalued or downgraded by the unit (i.e. loved object), initial anger may be usefully and reasonably directed toward it (Fairbairn 1952 in Summers, 1991). For many in the researched population, however, such was their love for their unit and those in it, the direction of this anger was somewhat perverted.

Without the subjective position to negotiate ambiguity or indifference, objects (and their self-representations) cannot be both good (loved) and bad (hated). To keep these representations separate, and to maintain idealisation of the unit and denial of the self, the "all good" position was afforded to the unit and "all bad" to the self, lest anxiety engulf both these positions. Therefore, anger that would normally be directed toward the lost unit (or towards the army more broadly) was, to a large extent, redirected toward the self, and this anger underpinned the depressive position. Indeed, "the depressed person "may [know] whom he has lost, but not what he has lost in him" (Gomez, 2017, p. 9), namely, the role that the lost loved object played in the individual's sense of self.

Given the demands placed on identity in the military and during transition, and the impact these demands have on feelings of anxiety and depression, veteran mental health may be understood to exist on a spectrum. At the healthy end of the spectrum, adaptive splitting may promote collective identification (bonding), courage, and thereby capability. Over time, however, these adaptive processes may alienate parts of self from the self, and thereby others, which are necessary to sustain identity. In and upon changing social and occupational context, feelings of alienation may precede loneliness, which is further magnified because attempting to connect with others with whom one *cannot* identify produces anxiety, and the loss of those with whom one *could* identify triggers anger and depression.

At the more severe end of the spectrum, when these positions become more rigid, and are associated with the reduced capacity to reflect and symbolise, they may present as PTSD; should they become more rigid still, they may present as personality disorders. As mentioned in Chapter 1, evidence tells us that the comorbidity of depression, PTSD, and potential personality disorders in veteran cohorts are as high as 31%-79% (Dunn et al. 2004).

Regardless, if mental health disorders in the military and veteran population exist on a spectrum, the mechanism of splitting, so critical to combat, may be associated with pathology. Such pathology stems from “the failure to develop the integrated object relationships out of which an integrated ego and super ego [self] emerge” (Kernberg in Summers, 2014, p. 198), a task more typically associated with adolescence (Kroger, 1996).

7.2.5 Healthcare avoidance

One of the concerning serious consequences of these adaptations may present as a reluctance in military personnel and veterans to engage with healthcare providers—a phenomenon well documented in the literature, and previously outlined in Chapter 1. In the current study, healthcare avoidance was specifically attributed to issues of identification and trust along with personal agency (Chapter 4).

A further reason for healthcare avoidance might be that clinicians are placed in a position of metaphorically holding a mirror to the wounded, injured, or ill soldier, where that which is reflected back to the individual may be of an unfamiliar or unwanted image, complete with the traits, behaviours, and conditions previously disavowed. This reflective process places the soldier in the position of having to face and potentially merge (identify) with a bad object, in which case a loss of identity and feelings of annihilation may ensue. Accordingly, the potential and predicted clinical relationship is almost the complete antithesis of relationships that participants had with their peers, which was not only based on trust, but also immense

validation. For this population, to see signs of an in-valid, characterised by vulnerability, limitations, and flaws, would be conceptually extremely difficult, given their adaptations to war. In this case, the adaptive mechanism of denial may continue to operate, thus allowing participants with minor impairments (or at least, those that do not immediately see them removed from service) to continue in their role, despite the inherent risks of worsening physical and psychological symptoms.

Conceptually, these defenses/adaptations that guard against threats to identity are plausible, especially given the increasing level of felt fragility participants anticipated as they imagined themselves outside the context of their unit, including withdrawal from the combat addiction they described in Chapter 3. Indeed, many withdrawal symptoms experienced by those addicted to substances and relationships—namely anxiety, depression, difficulty concentrating, irritability, anger, restlessness and, impatience (Gilbert, Gilbert and Schultz, 1998)—were experienced by participants and observable through their behaviour during rehabilitation.

7.2.6 Self-destructive behaviours

No matter the extent to which participants avoided healthcare prior to sustaining the serious wound, injury, or illness that admitted them to the current study, their speech and reported behaviours suggest that rehabilitation was marked with the task of coming to terms with being someone they previously disavowed. This forced fusion highlights the two representations of self—that which is good or powerful, and that which is bad or vulnerable—that must be negotiated and integrated into a singular coherent self to form total object representation in themselves (Kernberg in Summers, 2014), and thereby lay the foundations for mature and fulfilling relationships with others.

Initially lacking this integration, participants appeared to exist in a split state of limbo. In this state, they perceived themselves as no longer who they were, and yet did not know who they would become; this prompted a diffusion of anxiety across the division of good and bad (Kernberg, 1967 in Blass, 2015). Such was the fear, dread, and feelings of annihilation associated with self-exposure (Modell, 1968), some participants displayed overtly self-destructive behaviours which seemed to represent their desire to actualise their psychic reality during transition. Rather than going from being some-one good and somewhat powerful to some-one who is bad and vulnerable (which was unacceptable, and therefore split off), some participants seemed to adopt a position as no-one. To achieve this outcome (or illusions of it), some hid from others by “hiding behind bushes” and cutting ties with the unit (see Chapter 6), and others hid from themselves by abusing alcohol and prescribed medication (e.g. quote *5.17*

"I was sitting at home, doing [abusing] endone. … I just lost all hope"). Some even contemplated suicide. Drawing on the parallels between combat veterans and the highly adaptive processes often associated with adolescence (see Chapter 6), the crisis of identity faced by participants was well described by developmental theorist Erik Erikson, thus:

> … many a late adolescent, if faced with continuing diffusion, would rather be no body or somebody bad, or indeed, dead—and this totally, and by free choice—than be not-quite-somebody. The word "total" is not accidental in this connection, for I have endeavoured to describe in another connection a human proclivity to a "totalistic" reorientation when, at critical stages of development, reintegration into a relative "wholeness" seems impossible.
>
> (1956, p. 88)

The similarities between identity crisis in adolescence and that experienced by military personnel undergoing rehabilitation and transition is now further explored.

7.2.7 Leaving the unit, leaving the family

It is perhaps not surprising that adaptations to combat occur within this population because they functioned to bond participants to their task and team; this rendered relationships within the unit as, not only structurally like a family (Modell, 1968), but also affectively so. Accordingly, there are many parallels that exist between the participants' descriptions of their own behaviour, relationship styles, motivations, and coping mechanisms, and those of adolescents. Similarities included a tendency toward service and risk, feelings of omnipotence, the importance of peer validation, strong emotions, and the need to push boundaries. In addition, the language that participants used to describe their peers, that is "boys" (see quotes 3.40, 5.16, 6.34, 6.38, and *6.40*), "family" (see quote *3.43*), and "brothers" (see quotes *3.43* and *3.44*) gives further credence to the existence of their primary or quasi-familial relatedness within the structure of their unit. One participant even described his motivation as similar to the way "kids revolt against their parents" (see quote *6.4*). The desire for the adolescent to serve or be a part of an-other is well documented and Erikson encapsulated this notion in asserting that "the late adolescent wants to be an apprentice, or a disciple, a follower, sex mate or patient" (1956, p. 88). In part, this suggests that the adolescent, and in this instance, the soldier, is most apt to be defined in relation to an-other, and may experience anxiety that may come with being just themselves.

The parallels between this population and that of adolescence can be further ascertained through consideration of Erikson's (1956) description of what usually occurs when adolescents can no longer be the "apprentice, or a disciple, a follower, sex mate or patient"—positions that hinder individuality and separateness, thus:

> If this fails, as it often must from its very intensity and absoluteness, the young individual recoils to a position of strenuous introspection and self-testing which, given particularly aggravating circumstances … can lead him into a paralysing borderline state. Symptomatically, this state consists of a painfully heightened sense of isolation; a disintegration of the sense of inner continuity and sameness; a sense of overall ashamedness; an inability to derive a sense of accomplishment from any kind of activity; a feeling that life is happening to the individual rather than being lived by his initiative; a radically shortened time perspective; and finally, a basic mistrust [gendered language in the original].
>
> (1956, p. 81)

Eriskson went on to suggest that there is a societal and clinical obligation to help those undergoing such transitions to be themselves. He suggested this circumstance "leaves it to the world, to society, and indeed to psychiatry to prove that the patient does exist in a psychosocial sense, i.e. can count on an invitation to become himself [gendered language in the original]" (1956, p. 81). If this observation holds in this context, it indicates the degree and type of support some may need as they transition from the military.

7.4 Maturing into relationships with self and others

During combat, omnipotence, devaluation, idealisation, and denial were adaptive mechanisms employed as a result of splitting, to enable mission success. During rehabilitation and transition, these adaptations were experienced as distressing for participants, yet some also talked about the ways they overcame their distress. While adaptations to combat involved splitting to create identification and connection with those considered powerful and good, it also served to repudiate identification and destroy connectedness with those who did not share these features. In contrast, adaptation in rehabilitation involved connection with features previously disavowed, in both the self and others, which brought about a paradoxical "position of strength" (see quote *6.25*).

For those primarily diagnosed with physical issues, this connection (or re-connection) was achieved through the opportunity and ability to reflect (and thereby symbolise and make psychological links) between self and others—a process that helped them gain perspective, accept their situation, and develop ideas about themselves for the future (see Chapter 6). These connections appeared to be made in sequential stages, with each stage underscored by a unique value (or set of values). Collectively, these stages demonstrated a clear process of self-other rebalancing, as well as individuation and separation during rehabilitation, similar to the task of adolescence. In conjunction with clinical care, awareness of the values drawn upon by participants and the stages in which these occurred may contribute towards the development of a useful model that frames rehabilitation and transition from the military in a way which

can account for the experiences and perceptions of veterans themselves. Those transitioning with severe psychological illnesses, however, appeared to struggle with reflection and symbolisation, highlighting the challenge they, and those caring for them, continued to face. These individuals may require more structured assistance to experience themselves as agentic individuals—a state bound with issues of identity (American Psychiatric Association, 2013).

7.5 Implications

7.5.1 Facilitating transition

Notwithstanding the need for personal responsibility (a value drawn upon by participants in both operations and rehabilitation), the construction of the self that emerges through adaptations to dissociation in combat may render this task difficult, in and across changing social and occupational contexts. Just as dissociation represents a potential space and opportunity for identity development or decline (Winnicott in Ogden, 2014), so too does transition. Evidence of poor health outcomes in veterans suggests that current support structures available during rehabilitation and transition do not work to facilitate identity development, specifically in this context, with the task to separate from the collective as an integrated whole.

To support veterans achieve an individual and integrated identity as they adapt to a new context and culture, it may be necessary to develop an overarching transition framework that facilitates the development of selfhood. This requires a facilitating environment, one where regression and vulnerability may be safely achieved (Zetezel 1956, cited in Modell, 1968; Winnicott, 1965), allowing for self-constructs to reconstitute, for mistakes to be made, and new realities tested (Modell, 1968). As others have noted, this is critical, as "maturation (in psychology) requires and depends on the quality of the facilitating environment" (Winnicott, 1965, p. 180) whilst "a failure of the holding environment leads to a failure of identification" (Modell, 1968, p. 86).

Given the parallels established between the tasks of facilitating adolescents and those facing veterans during rehabilitation and transition, it may be useful to consider conditions proposed as optimal in assisting adolescents during self-other differentiation. As an example, Kegan proposed the following optimal conditions:

> When it is functioning optimally, each culture of embeddedness (1) holds securely (confirms and recognizes [the individual]), (2) lets go at an appropriate time (contradicts and assists differentiation), and (3) remains in place to see its guest through the transition to a new balance.
>
> Kegan 1982 in Kroger (1996, p. 168)

The culture of embeddedness mentioned here can be usefully conceptualised in this context as extending from the military unit within which transitioning members serve, to the wider veteran or general community to which they settle. Thus, the military, the health system, and society must work together to support military personnel in rehabilitation and transition by assisting them to integrate into a more coherent whole that can better relate to parts of themselves, and thereby to others. It is proposed this may be achieved by supporting veterans to answer two questions that correspond to the American Psychiatric Association's (2013) definition of self: Who am I (identity)? And, what could I do (self-directedness or agency)? Some suggestions on how this may be achieved are now offered.

7.5.1.1 Who am I?

A military to civilian transition framework must account for the individual who holds unique past experiences and unique potential for the future, and who may need to cohere toward a more complex and mature self (see Chapter 6). This would ideally be achieved through focus on two processes. First, through promoting or restoring the intrapsychic ability to link and symbolise, an ability which underpinned the ability to reflect on self in relation to others, and thereby adapt; and second, by drawing out identity through recognition of held values, further promoting psychosocial connection, feelings of worth, and individual identity. Though often left unspoken, values are the core of personal identity and help inform who someone might become (White, 2001, 2004, 2007). For veterans, some values will be unique to those transitioning and other values may be those inculcated through military service. Either way, identifying these aids in efforts to support restructuring of the self in relation to others, and may support military personnel to prepare for the individuation and interpersonal functioning necessary to separate from the collective.

7.5.1.2 What could I do?

Drawing on the results of Chapter 3, wherein participants described the affective bonds they held with their team (objects) *and* with their task (objectives), it is important to consider the way veterans (can) come to know themselves again through occupation and industry. This is important because what participants *did* was described as affectively significant as those with whom they did it. In part then, their previous identity was anchored in doing something meaningful and it was this desire that saw them first enter into the military, and then their high-risk combat unit. This need "to do" can be harnessed but may require some facilitation by society, and adjustments by the individual, just as would be required of an adolescent leaving their family.

One of the adjustments to be made by the individual as they learn to adapt to the occupations and industry of civil society, is learning to experience the ambiguity inherent in this context—to tolerate the liminal space, which is fraught with anxiety and yet loaded with potential. This learning requires experimenting, which invariably involves testing and failures, just as adolescents experiment with identity. In conjunction with moving through this liminal space, participants should be helped to recognise that this process is necessary, and that 'failure' to 'fit' within a given occupation is not failure, but part of establishing 'who I am,' in part through experiencing 'who I am not.'

For these reasons, there may be utility in trialing a Commonwealth or government-supported 12-month veteran internship across multiple industries. This might involve three to four departmental rotations over 12 months, during which time a veteran would be afforded opportunities to build relationships with others—and in doing so, learn more about themselves, testing their new reality (by way of limitations and potential) in a new occupational context. Ideally, such an internship would be characterised by opportunities for creativity, yet allow for regression with support and without judgment. This may be considered a form of occupational holding, recognising, and confirming (Kegan 1982 in Kroger, 1996).

Notwithstanding the individuation that appears an essential task to facilitate successful transition, it may be especially useful to provide opportunities to build on existing strengths, perhaps supporting veterans toward pathways that build on the prosocial values explicitly inculcated in service. These may include pathways to health, education, humanitarian, and philanthropic services, at the national, state, and local governing levels.

So far, the parallels between veterans and adolescents, as each move from their primary or familial units and toward separation, have been usefully identified. These parallels have framed argument regarding the potential needs of veterans as they individuate in terms of discovering who they are, and the ways in which governmental bodies and civil industry can help facilitate what they might do. As mentioned above, and previously in Chapter 1, parallels between veterans and adolescents stem from the structural and affectionate relationships that occur in the military, and that are based on survival. These relationships are formed on the condition of role performance but when that role is no longer available due to physical or psychological change, the consequences of adaptations to war become evident. These consequences include feelings of alienation, loneliness, and anxiety when attempting to connect with others, as well as the anger and depression that accompanies perceptions of devaluation, rejection, or abandonment.

Leaders within the military (and the military itself) must also be considered in familial terms because of the familial relationships that underpin many of these positive and negative outcomes. Others have usefully likened military leaders to parents (Manning, 1994; McIntosh, 1995; Siebold, 2007; Wessley, 2006), which is a position incumbent with responsibility. One of the responsibilities of parents may be to support those in their charge to healthily separate from the primary unit, to become individuals capable of contribution and relationship. This would involve mitigating issues of identification which develop as adaptive in the military and maladaptive outside of it, especially when military personnel are forced from their role by way of serious wounding, injury, or illness. One way to mitigate such an abrupt relational disjuncture is to consider the use of transitional objects to help the individual separate, at least in part, from the familiar, and the familial. Indeed, this would be the task of a "good" parent who wishes to see their charges mature into functional and contributing members of society.

7.5.1.3 Transitional objects: peer counsellors and networked clinical care

Transitional objects are those who represent minimal difference between self and others (Modell, 1968; Winnicott, 1953) and who become a symbolic reference point, through which new self-constructs may be achieved. Although transitional objects were originally posited as critical around childhood development, it has been asserted that "the role of transitional objects … are also of relevance to other times of rebalancing during the lifespan" (Kroger, 1996, p. 194).

Transitional objects may become a key component of a psychologically-framed primary healthcare system, one which would ideally support veterans as they find out who they are and what they could do, both in and moving between the garrison environment and civil society. This supportive system would ideally build upon military personnel's and veterans' perceptions of health, articulation of need, and what they value, such as the need to seek care from those with whom they could identify, by way of shared experience. In the military, the introduction of transitional objects may include augmenting medical and psychological services with peer-to-peer counsellors who have personal experience in rehabilitation. In this instance, such counsellors would represent part-good object (i.e. they share features that can be identified with, such as combat experience) and part-bad object (i.e. they also share features of vulnerability—a state to which participants must adapt). For those rehabilitating in the military, peer support counsellors may include those who have also experienced rehabilitation, and remained in service. For those transitioning, these counsellors may be ex-service men and women who have successfully individuated and separated from the military.

Nonetheless, although veterans as peer counsellors may have a useful role within service and during transition to civil society, there exists another significant opportunity for veterans to develop a more complete identity. In this case, the civil medical system (or more importantly, those working in it) may be positioned as further transitional objects. Those able to offer such care would ideally have military experience themselves or at the very least, hold a strong interest in veteran health. Based on the current results that veteran (and especially combat veteran) identities are forged in a way likely incomprehensible to many civilian clinicians, these initiatives must be underpinned by the development of military health expertise and a well-coordinated national network of health professionals.

7.5.2 Theory, research, and education

There are theoretical implications of this research, all which center on the notion that rehabilitation and transition out of service for high-risk combat personnel must be considered as culturally and conceptually distinct from that which occurs in relation to most civilians who leave an occupation. In short, theory must account for the relationships that participants develop during service, both within themselves and with others, and the impact that these may have on health and health behaviours, potentially over and above the impact of explicit wounds, injury, or illnesses. The reconceptualisation of object relations theory as applicable to relationship formation, and the process and structures of primary military units as analogous to processes and structures within primary family units (including separation from them), holds the potential to encompass the complexity of self in relation to others, during change and over time. More specifically, transition from the military under these circumstances should be considered as a third process of individuation and separation, one that builds on those proposed to occur at around age three (Mahler, 1974), and again in adolescence (Blos, 1967; Kroger, 1996).

This reconceptualisation of object relations theory, as it applies to the military, would involve a well-framed research and education agenda that would be enhanced by nationally mandating education in veteran health as a post-graduate pathway. Such a mandate would ideally include studies that specifically address veteran health, such as a Masters in Military Psychology, a Masters in Veteran Counselling, and post-graduate studies for general practitioners and other health professionals, as well as peer workers. All of this would both require and support a strong network of engaged clinicians and ex-service organisations that share language and can work with one another, in caring and supporting veterans during rehabilitation, and through military to civilian transition.

7.5.3 Extending theory

The implications of this research, however, may have relevance for other occupations in which identity is fused with task and team. These might include professional athletes and dancers, or high-risk/trauma-response professionals such as police, ambulance, and firefighting personnel. In all these contexts, the needs of the individual are subjugated to the needs of the role, a role which involves the experience of fear, flow, and intense affect (albeit in different contexts). They also demand courage in order to function as required by self and others. Having created such a functional professional in context, the military and these other organisations arguably have moral obligations to acknowledge that desired traits and behaviours may present as dysfunctional out of context, and to help facilitate the development of a new individual identity that is separate from these roles. Such an identity would ideally be related to and built upon that which has gone before, and come to exist in a more mature and complex form, with enhanced capacity for humility, compassion and gratitude—all of which serve to develop or re-develop relationships with others.

7.6 Conclusion

It seems a truism to state that a combat soldier's identity is affected by collective military training, combat, experiences of wounding, injury, and illness as well as rehabilitation and transition. Each of these conditions and experiences offer unique opportunities that shape and enable expression of identity. In turn, identity shapes and enables the expression of agency, which influences health behaviour and health outcomes. Despite this, there has been no broad theoretical base proposed to assist in understanding how a soldier's identity, and potential shifts in identity during times of change and transition, may impact on psychological health or health behaviour, either within or beyond the military. Psychodynamic object relations theory, as means to understand veterans' transitions, can clearly provide a required theoretical framework to inform the development of military and veteran health services, and inform psychotherapeutic intervention. Given the physical and psychological demands of soldiering, there is both a moral and fiscal imperative to consider the constructs of self in the delivery of veteran healthcare, with an associated greater need for dialogue around veteran self-other rebalancing at the critical times of change, such as during rehabilitation and transition.

However, 'being' an individual—what it means to function as an independent individual, and perhaps particularly in the western capitalistic individualistic ethos—is likely to be incongruent with a soldier's developed value system and worldview. This incongruence (unless managed well) may overwhelm an individual's capacity to cope, leading to negative health behaviours and social outcomes. Through the application of an object relations

framework, primary healthcare providers and others may be in a unique position to assist veterans to transition from collective military culture as more self-aware, compassionate, and mature individuals, and in doing so, to help create a more self-aware, compassionate, and mature civilian culture. This will not only address society's obligation to meet the needs of those who have offered so much, it may also enrich our own worldview, as we learn from those who have so much to offer.

Appendices

Appendix 1: Questions and prompts for first series of interviews

Physical Health

In red, can you mark one or more times, when you were at your best physical health?

[Mark]

What was happening then? (Prompts: behaviours, exercise, diets)

And at your worst?

[Mark]

What was happening then?

Can you explain the shift?

Mental Health

In blue, can you mark one or more times, when you were at your best mental health?

[Mark]

What was happening then? (Prompts: sleep, substance use, moods/emotions, motivation,)

And at your worst?

[Mark]

What was happening then?

Can you explain the shift?

Social Health

In green, can you mark one or more times, when you felt a strong sense of belonging?

[Mark]

What were relationships like then, with your

- Family?
- Friends?
- Peers?

And when did you feel the most isolated?

[Mark]

What was happening then?

Can you explain the shift?

Medical Employment Category (MEC) Change

How have things been since the MEC change? (Prompt: has anything changed)?
Has the MEC change, impacted the way you relate to others? (Prompt: at the unit? At home?)
What is important in your life now?
How do you see yourself in the future?

Rehabilitation

Since your MEC change:
What has been helpful to you?
What has been unhelpful?
Who has helped?
Who didn't help?

Others

What are your observations about others going through the rehabilitation process?
Is there someone going through this (or has gone through it) who you admire?
    What is it about them that resonates with you?
Can you think of someone who is not doing so well?
    What is making it hard for them?
If you could change something about rehabilitation, what would it be?

Appendix 2: Prompts for second series of interviews

Interview 2 Guide

Can you tell me where you are in your rehabilitation now?

Is there anything that was significant to you in relation to the last interview, that we can get a chance to talk about at that time?

After analysing the last interviews I have identified some themes and I want to dig deeper into these to gain more insight. Some of these may be very close to your experiences and some themes may more to others. Some may not make sense to you at all, and if that's the case please let me know.

Are you ok if we now talk about these things?

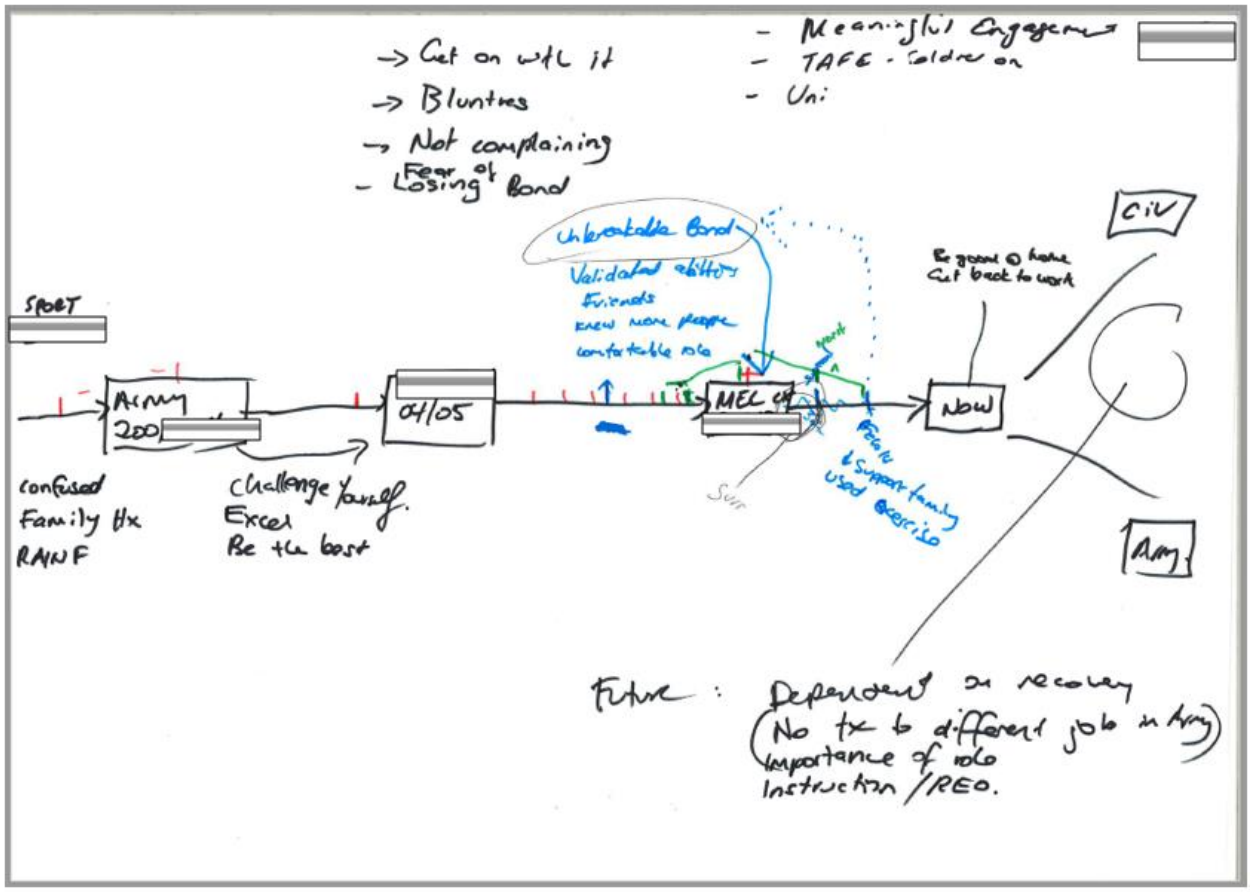
- Loss and Limbo
- Health care avoidance for mental and physical health issues.
- Health behaviours and change
- Accessing care
- Pushing and Proving
- Identification with others
- Increased Empathy and compassion
- Emotions around operations

Is there anything else you would like to bring up?

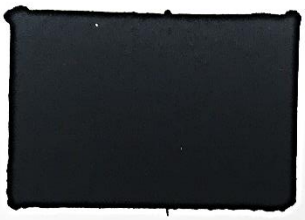
Thank you very much for helping.

Appendix 3: Sample of timeline

Sample of timeline as worked through by researcher and participant in first series of interviews (researcher's handwriting at participant request).



Appendix 4: Invitation to participate



THE UNIVERSITY of ADELAIDE

From Well to Wounded and Back Again: The Experience of High Risk/Highly Cohesive Soldiers Undergoing Rehabilitation in the Australian Army.

Thank you for considering participation in this research project. My name is Paula Dabovich and I am both an ADF member and a student researcher with a research team from the University of Adelaide and Centre for Traumatic Stress Studies. In this project we hope to learn more about the personal experiences of injured [redacted] personnel as they adjust and recover from serious physical and/or psychological injury.

Below are answers to some questions you may have:

What is this research about?

Whilst working in your unit in 2010 and 2011 I became aware of the need to learn more about injured soldiers' experience during physical or psychological recovery. This research will fill a gap in knowledge by giving a better understanding of the recovery experiences of injured soldiers. We hope that sharing the things we learn will help others undergoing recovery at [redacted]. It may also help those in command, academics, policy makers, psychologists, psychotherapists and other medical and allied health professionals to provide the best care for others like yourself.

Who will benefit from the research?

In the short-term, this research may benefit current and future cohorts of wounded soldiers from [redacted] who are undergoing rehabilitation, by assisting in creating a unit specific recovery framework. Insights gained from the research may also be of interest to [redacted], the ADF and allied military forces in developing their rehabilitation and transition practices.

In the long-term, this research will provide medical practitioners, psychologists and allied health professionals with unique insights into your experiences so they may better understand and meet the needs of others in your situation in the future. In order to contribute to the veteran health body of knowledge, and influence veteran care, the research may be published in relevant psychological, military and/or health-care journals and presented at academic events like conferences.

What will be asked of me?

If you would like to participate in the research, please contact me by either telephone, email or by sending me the attached response form in the pre-paid envelope (provided). I will initially arrange to meet you at a time and place convenient to you, in order to fully explain the research and make sure you are happy to take part. If you would like, you can bring a friend, family member or support person to this meeting. I will provide you with a consent form at this point and if, after 24 hours, you are still interested in participating in the research, you can return the consent form to me in a pre-paid envelope that I will provide, and I will contact you to organise our next meeting. The consent form does not bind you and **you are free to withdraw from the research at any time.**

Unlike most research, you will not be required to fill out any forms. This research is not interested in numbers or statistics, but about hearing your story, your thoughts and feelings, and your insights about your journey. Because we think that these things can change over time, and so we can just follow up on some things you might talk about, we will ask if you'd like to participate in 2-3 in-depth interviews over a one year period. You can say yes to this,

but then change your mind later – it is up to you. We will record your story just to make sure that we get it right, and then convert it into the written word so that we can analyse it later. We will change any identifying information (like names and places) before we analyse it.

It is possible that we may conduct further research in this area in the future. We seek your permission to contact you at that time to invite you to participate in such studies: you do not have to agree to do this – even if you agree to participate in this study.

You will have the opportunity to review the transcripts, and your position in it, prior to publication. You can withdraw any information you have provided at any time or to withdraw from the research at any time, without any consequence or needing to provide an explanation. You should not feel obliged or coerced into participating. It is completely your decision whether or not you agree to be part of this study.

Is the research endorsed by [redacted]

Yes, the research was initiated under the command of [redacted] and is fully supported by [redacted]. You will be considered 'on duty' during any face-to-face engagement with the research team.

What about confidentiality and my protected identity status?

All information provided by you will adhere to protocol surrounding your protected identity status.

After consent, you will be referred to only by nickname and/or unique study ID number. Neither your name nor any identifying factor will be made available when we refer to what has been said during interviews. The ADF, DVA or general public will not have access to information you provide, nor will they be able to link any information provided back to you.

You may or may not choose to inform your chain of command, colleagues, family or friends about the research, it is up to you. Even if you decide to not tell anyone about participating in the research, in a cohesive unit such as [redacted], there will always be some risk of other unit members finding out about your participation.

As mentioned above we will ensure identifying information such as names, places and events are disguised. To further ensure your anonymity we will not refer to specific details of injuries. Every effort will be made to ensure information provided cannot be traced back to you specifically. You will be given the opportunity to review the transcripts prior to analysis and may withdraw any information.

Further information regarding the voluntary nature and informed consent relating to this research may be found in the attached flier: Australian Defence Human Research Ethics Committee – Guidelines for Volunteers.

Will this affect my career, compensation or DVA status?

Not at all. A decision to either participate or not participate in this research will have no bearing your career, compensation or DVA status.

Who are you, Paula?

I joined the Army Reserve (NORFORCE) in the early 1990s, later joining the ARA and graduating from Duntroon in 1995. I served as a RAEME officer until 1999 when I left the Army to become a Registered Nurse. I worked in both Emergency and Community Health settings at Sutherland Hospital, NSW where I developed a particular interest in veteran community groups living with chronic health conditions. I returned to service in 2008 as a Medical Corps General Service Officer and was attached to your unit in 2010 to roll out welfare initiatives after the [redacted] have been involved with [redacted] ever since.

I have moved to Adelaide to conduct this research under the guidance of some of the best

academics Australia has to offer. The research is being supervised by Dr Jaklin Eliott from Adelaide University's School of Population Health, Dr Miranda Van Hooff from Centre for Traumatic Stress Studies and GPCAPT Professor Alexander McFarlane who heads the Centre for Traumatic Stress Studies.

I have been appointed to the Mental Health Sub-Committee of the South Australian Veteran Health Advisory Council, where I collaborate with veterans of all eras, including several contemporary SF soldiers, as well as ex-service organisations such as Soldier On and RSL.

I here act in my capacity as a research student within the University, with the support of [redacted] I will be working with you in an academic capacity as a researcher within the University of Adelaide, therefore rank and military status has no bearing on our relationship. To reinforce this position, I will conduct research in civilian clothing and if you feel comfortable, I would be pleased if we could relate on a first name basis.

As a member of [redacted] I may be engaged in [redacted] activities over the next few years, which will be conducted from Adelaide. This, once again, has no bearing on this research or our relationship.

What now?

I encourage you to discuss your decision to participate in this research with a trusted health professional, peer or family member. If you would like to learn more about participating in this research, please contact me by phone or email (below) or by using the provided pre-paid envelope. We can then arrange a meeting, during which, we can discuss the research in more detail, address any questions you may have and talk about consent. Feel free to have a trusted health professional, peer or family member attend this meeting, especially if you are experiencing any mental health issues. I will contact you within a few days of our meeting to ask if you would like to participate. Formal consent will not be sought for at least 24 hours after this meeting.

Paula Dabovich
Masters Level Researcher
L11, Terrace Towers Building
178 North Terrace
Mail Drop DX 650 205
The University of Adelaide SA 5005

Mobile:

Email:
paula.dabovich@adelaide.edu.au

Please cut/tear and return in envelope provided:

From Well to Wounded and Back Again: The Experience of High Risk/Highly Cohesive Soldiers Undergoing Rehabilitation in the Australian Army

Potential Participant

Name: _____

Phone: _____ Alt. Phone: _____

DRN email: _____ Alt. email _____

(Please circle preferred email)

Appendix 5: Australian Defence Force Human Research Ethics Committee Guidelines

ATTACHMENT B TO
ADHREC/OUT/2012/R17133717

AUSTRALIAN DEFENCE HUMAN RESEARCH ETHICS COMMITTEE— GUIDELINES FOR VOLUNTEERS

Thank you for taking part in Defence Research; your involvement is very much appreciated. This pamphlet explains your rights as a volunteer.

What is the Australian Defence Human Research Ethics Committee?

- ADHREC is the Australian Defence Human Research Ethics Committee. It was established in 1988, to make sure that Defence complied with accepted guidelines for research involving human beings.
- After World War II (WWII), there was concern around the world about human experimentation. The Declaration of Helsinki was made in 1964, which provided the basic principles to be followed wherever humans were used in research projects.
- The National Health and Medical Research Council (NHMRC) in Australia has published the *National Statement on Ethical Conduct in Human Research* (NHMRC 2007). This *Statement* describes how human research should be carried out.
- ADHREC follows both the *Declaration of Helsinki* and the NHMRC *Statement*.

What Australian Defence Human Research Ethics Committee approval means

- If you are told that the project has ADHREC approval, what that means is that ADHREC has reviewed the research proposal and has agreed that the research is ethical.
- ADHREC approval does not imply any obligation on commanders to order or encourage their Service personnel to participate, or to release personnel from their usual workplace to participate. Obviously, the use of any particular personnel must have clearance from their commanders but commanders should not use ADHREC approval to pressure personnel into volunteering.

Voluntary participation

- As you are a volunteer for this research project, you are under no obligation to participate or continue to participate. You may withdraw from the project at any time without detriment to your military career or to your medical care.
- At no time must you feel pressured to participate or to continue if you do not wish to do so.
- If you do not wish to continue, it would be useful to the researcher to know why, but you are under no obligation to give reasons for not wanting to continue.

ATTACHMENT B TO
ADHREC/OUT/2012/R17133717

Informed consent

- Before commencing the project you will have been given an information sheet which explains the project, your role in it and any risks to which you may be exposed.
- You must be sure that you understand the information given to you and that you ask the researchers about anything of which you are not sure.
- Before you participate in the project you should also have been given a consent form to sign. You must be happy that the consent form is easy to understand and spells out what you are agreeing to. Again, you should keep a copy of the signed consent form.

Clinical trials.

- The NHMRC requires that the researcher provide a nominal roll of study participants where the study is a clinical trial (eg when the researchers are trialling a new treatment or device). For trials conducted by large Defence institutions like the Defence Science and Technology Organisation, the Submarine and Underwater Medicine Unit, the Army Malaria Institute, the Institute of Aviation Medicine or the Centre for Military and Veterans' Health, this roll is kept by them on ADHREC's behalf. These records will not be used to consider your medical employment standard or for compensation purposes.
- All ADHREC protocol files are secured in a locked filing cabinet and only the Secretariat has access to these. ADHREC will not pass your contact information to a third party without your permission.

Complaints

- If at any time during your participation in the project you are worried about how the project is being run or how you are being treated, then you should speak to the researchers.
- If you don't feel comfortable doing this, you can contact the Executive Secretary of ADHREC. Contact details are:

Executive Secretary
Australian Defence Human Research Ethics Committee
CP3-6-036
PO Box 7912
CANBERRA BC ACT 2610
AUSTRALIA

Tel (02) 6266 3807
E-mail: ADHREC@defence.gov.au

More information

If you would like to read more about ADHREC, please visit the ADHREC website at: http://www.defence.gov.au/health/research/adhrec/i-adhrec.htm

Appendix 6: University of Adelaide Human Research Ethics Committee Guidelines

The University of Adelaide
Human Research Ethics Committee
(HREC)

THE UNIVERSITY of ADELAIDE

This document is for people who are participants in a research project.

CONTACTS FOR INFORMATION ON PROJECT AND INDEPENDENT COMPLAINTS PROCEDURE

The following study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee:

Project Title:	From Well to Wounded and Back Again: The Experience of High Risk/Highly Cohesive Soldiers Undergoing Rehabilitation in the Australian Army.
Approval Number:	**ADHREC: 738-13** **UoA: H-2013-098**

The Human Research Ethics Committee monitors all the research projects which it has approved. The committee considers it important that people participating in approved projects have an independent and confidential reporting mechanism which they can use if they have any worries or complaints about that research.

This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research (see http://www.nhmrc.gov.au/publications/synopses/e72syn.htm).

If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, you have three avenues for resolution which are as follows:

1. In the first instance, please feel free to consult the project co-ordinator:

   Dr Jaklin Eliott
   Research Supervisor
   The University of Adelaide
   Phone: 08 8313 3855
   Email: Jaklin.eliott@adelaide.edu.au

Appendix 7: Interview checklist

From Well to Wounded and Back Again: The Experience of High Risk/Highly Cohesive Soldiers Undergoing Rehabilitation in the Australian Army

Interview Check

Participant Number/Nick Name: _____

Interview Number: 1 / 2 / 3

Original Written Consent: Yes / No

Dated: _____

Verbal consent for this interview and recording: Yes / No

Date:_____ Time:_____

Please check:

- Power imbalances in military–no longer military relationship (researcher only)
- Fully voluntary
- Support plan for after interview if feeling distressed
- Chaplain aware of an interview taking place
- If remote interview with displaced: Peer advised to call within 24hr

Researcher: Paula Dabovich

Signature:_____

Date: _____

Appendix 8: Consent

THE UNIVERSITY of ADELAIDE

RESEARCH CONSENT FORM

1. I have read the attached Information Sheets: Australian Defence Human Research Ethics Committee (ADHREC) – Guidelines for Volunteers and The University of Adelaide (UoA) Contacts and Complaints Procedure.

2. I agree to take part in the following research project:

Title:	From Well to Wounded and Back Again: The Experience of High Risk/Highly Cohesive Soldiers Undergoing Rehabilitation in the Australian Army.
Ethics Approval Numbers:	**ADHREC: 738-13** **UoA: H-2013-098**

3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.

4. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.

5. I have been advised I am free to have a member of my family, friend or trusted health professional act as my advocate whilst I participate in the research, especially if I live with mental health issues.

6. Although I understand that the purpose of this research project is to inform the provision of services used to assist soldiers undergoing recovery, it has also been explained that my involvement may not be of any benefit to me.

7. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.

8. I understand that I am free to withdraw from the project at any time and that this will not affect medical advice in the management of my health, or my career, now or in the future.

9. I agree to the interview/s being audio recorded. Yes ☑ No ☐

10. I agree to be contacted to discuss future follow-up research. Yes ☐ No ☐

11. I am aware that I should keep a copy of this consent form, when completed, and the attached Information Sheets.

Participant to complete:

PMKeyS and Name:

Signature:

Date:

Researcher/Witness to complete:

I have described the nature of the research to:

and in my opinion she/he understood the explanation.

Name:

Signature:

Position:

Date:

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