The return of the traumatized army veteran: a qualitative study of UK ex-servicemen in the aftermath of war, 1945 to 2000

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Abstract

The challenge of transition from service to civilian life is explored through the experiences of a sample of 225 UK army veterans between 1945 and 2000. All subjects had a war pension for a psychological disorder and most had served overseas in combat roles. Statements about issues of adjustment and health were analyzed by the constant comparison method. Although twenty themes were identified, three ("anxiety, nerves and depression," "enduring illness attributed to combat exposure" and "illness interferes with the ability to find or keep employment") accounted for 46% of the total and were reported by between 53% and 86% of subjects. Consistency was observed in the ranking of themes over time. In content, they replicate those reported by veterans of recent conflicts, suggesting that the core issues of transition have an enduring quality. Most statements (66%) date from the 1940s, a time when the application process for a pension required the veteran to provide an explanation for his illness. A rise in the number of statements during the 1980s and 1990s reflected wider cultural acceptance of post-traumatic illness and veteran population entering retirement with time to reflect on defining experiences.

(200 mx)

Keywords

Veterans, transition, adjustment, psychological trauma

Introduction

In the immediate aftermath of World War Two, veterans who "had made satisfactory adjustments to civilian life before the war and to service life during the war" began to experience "severe difficulties under the stresses presented to them by their return to civilian life" (Main, 1947, p. 354). Dr Tom Main, himself a recently demobilized army psychiatrist, added that most of those so affected had not expected "to become ill-at-ease in familiar surroundings, phobic, depressed or irritable, asocial, confused, retarded, aggressive, antisocial or restless". It was hypothesized that difficulties of transition had adversely affected the "social, domestic or industrial" lives of a significant sub-group of veterans. During World War Two, it had been recognized that adjustment was particularly challenging for veterans who had suffered a post-traumatic illness. In 1943, a follow-up investigation of 120 servicemen discharged from the army with a psychological disorder found that "they were less usefully employed than before, earning less, less contented, less tolerable to live with, less healthy" (Lewis, 1943, p. 168). Only 50% could be classed as "socially satisfactory in respect of work and otherwise". Subsequently, Titmuss, a sociologist, observed that "the disturbances to family life, the separation of mothers and fathers from their children, of husbands from their wives… perhaps all these indignities of war have left wounds which will take time to heal and infinite patience to understand" (Titmuss, 1950, p. 538).

In the US, Alfred Schutz framed the challenge of transition in terms of group dynamics, arguing that the homecoming soldier made the "unwarranted assumption that societal functions which stood the test within one system of social life will continue to do so if transplanted to another system." He argued that the "sense of duty, comradeship, the feeling of solidarity and subordination" found in service life could not readily be replicated in civilian communities (Schutz, 1945, p. 375; Ahern, 2015). Indeed, the armed forces have been described as greedy institutions that demand a high level of social integration (Dandeker et al., 2003; Segal & Harris, 1993). As part of the assimilation process, recruits are often required to break ties with other institutions or individuals who might serve as a distraction from their duties (Coser, 1974). Group cohesion is encouraged because soldiers place their lives in danger to achieve success on the battlefield (Shils & Janowitz, 1948). Traditions, rituals, defined forms of dress and deployments apart from friends and family reinforce bonding and loyalty (Moskos & Wood, 1988). As a result, joining the services is often associated with the acquisition of an all-embracing, military identity. In recent years there has been a trend towards a civilian occupational model for the armed forces, though this

plausibly has less utility for armies in wartime when demands made of soldiers prioritize the needs of the group rather than the individual (Segal, 1986). A high level of social cohesiveness and the exclusion of those who do not integrate successfully heighten the issue of transition. The loss of personal connections and status are sometimes experienced as wounding because of the soldier's primary identification with the group (Binks & Cambridge, 2017). To achieve a successful reintegration in civilian life, the veteran will inevitably have to cope with feelings of rejection before being able to establish new bonds (Dandeker, et al., 2003).

The issue of transition for UK veterans has been researched by self-report questionnaire and semi-structured interview. An analysis of a randomly-selected, longitudinal cohort of UK service personnel showed that most veterans (87.5%) successfully managed the transition to civilian life as measured by settled employment (Iversen, et al., 2005). By contrast, those who had suffered from poor mental health during service encountered were found to be at greater risk of being unemployed and were more likely to report social exclusion. A further study of the cohort compared regular personnel with UK reservists on return from tours of Iraq or Afghanistan. The reservists were more likely to report feeling unsupported by the military and encountered difficulties with social functioning; these outcomes were associated with elevated rates of probable PTSD (Harvey et al., 2011). The issue of reintegration was explored in relation to 1,753 UK service leavers who were compared with regular serving personnel (Hatch et al., 2013). The veteran population was more likely to report reduced social participation outside work and greater feelings of isolation. Fewer social activities and smaller networks were also associated with higher reports of common mental disorders and probable PTSD.

Military service may not only have a profound effect on an individual's sense of identity but also the way that he or she views the rest of society. To explore the impact of military trauma on veteran perceptions, a sample of 114 UK war pensioners with an award for post-traumatic stress disorder (PTSD) were interviewed and compared with 39 veterans with a pension for a physical disability (Brewin, Garnett, & Andrews, 2011). The study found that veterans with mental illness reported significantly more negative changes to their view of the world. They spoke of a sense of alienation and disconnection, in part, because civilian society was perceived as malevolent and not appreciative of their military service.

Given that poor mental health has been shown to exacerbate the process of transition, the aim of this study is to explore the beliefs of UK veterans with a pension for a post-traumatic illness. It seeks to explore whether attitudes to their illness changed over a thirty-five-year period. The subjects are drawn from a random sample of World War Two pensioners with an award in payment from 1945 to 2000, who had previously been researched to identify temporal patterns of core symptoms (Engelbrecht et al., 2018). Case notes and medical records were researched to identify statements about issues of adjustment and illness. With recognition of the socio-economic context in which the narratives were presented, qualitative findings are presented to inform current challenges of veteran transition.

Research Design

Data Sources

Former members of UK armed forces, who suffered from an enduring impairment of function whether from a physical or psychological injury as a result of service, were entitled to a war pension. Financial compensation was awarded based on medical assessments, corroborated by unit records and paid according to standard schedules of compensation. Pension case files in the form of hard-copy, standardized forms and questionnaires included statements from veterans about their circumstances and illness. Veterans were required to attend a medical board at least once a year until their condition had stabilized and thereafter at a greater interval. Examined by two doctors, war pensioners were asked about their symptoms, ability to function and any difficulties experienced at work or home. Answers proved by veterans were recorded in the notes and this text, together with transcripts of statements gathered at appeals, form the basis of the study. The forms and procedures did not change during the timeframe, providing a measure of standardization. With a duty to prevent fraud, the Ministry of Pensions verified factual details from hospitals, family doctors, unit war diaries and employers. These narratives of the veteran's experience of illness were selected as the data source because of the range of information that they contain and the consistent method of recording evidence across the period of this investigation.

To collect representative data, a random sample was sought. Approximately, 50,000 war pensions were awarded for neuropsychiatric disorders suffered during World War Two,

representing 10% of the total in payment (Ministry of Pensions, 1953, pp. 97-98; Jones, Palmer & Wessely, 2002). The Ministry adopted the generic category, "psychoneurosis," to describe those with enduring psychological and psychosomatic illnesses relating to war (Ministry of Pensions, 1943). A random number generator was used to select 500 veterans with a pension for psychoneurosis, the sample being limited to former members of the British Army to avoid cultural differences between the three services (Engelbrecht et al., 2018). Ethical approval was obtained from the Institute of Psychiatry and Maudsley Ethics Committee, reference number 283/01.

Data Collection

The pension records of the 500 subjects were reviewed and statements in the form of free text were included in the study if they related to issues of transition or illness associated with adjustment and expressed directly by veterans themselves or indirectly by medical officers reporting an answer to questions. Of the 500 veterans, 225 offered relevant evidence. Narrative text was entered in NVivo v12, a qualitative data management software package to code and retrieve narrative evidence. All veteran statements were provided in the form of handwritten medical notes, letters or statements made at pension appeals. The length of each segment of text varied, some providing a single sentence and others lengthier paragraphs. Statements were reviewed for the presence of emotion or behavioral symptoms in response to a traumatic stressor. Illness referred to a range of mental health conditions that affected mood, cognitions and behavior which impaired social or occupation function or was associated with distress or disability.

Data Analysis

To analyze the statements, the constant comparative method was used; it involves coding each piece of text as a way of categorizing it into themes for interpretation (Glaser, 1965). The coding process involved three levels of analysis and was conducted by two of the authors (A.E and E.J). In the first stage (open-coding), the primary researcher read through the data for familiarization and assigned themes (A.E.), whilst the secondary rater (E.J.) read and assigned themes to one third of the case notes to ensure trustworthiness. Each researcher then checked the other researcher's coding and themes; discrepancies between raters were resolved through discussion (Braun & Clarke, 2006) and consensus was reached through face-to-face meetings. Initial detailed coding allowed the identification of different categories, properties and dimensions of veteran's adjustment and health experiences and

perceptions. A frequency count carried out in Excel spreadsheet enhanced the visibility of similarities and differences in cases. This aided the next step of coding (axial coding), where links between categories were made through a process of constantly integrating categories and their properties. During this stage, any inconsistencies were discussed and reconciled through meetings until consensus was reached. The coders agreed on the major themes. Where a disagreement arose on a coding (about 5% of cases), this was resolved by discussion. The final stage of coding (selective coding) enabled the researchers to identify and choose the core categories, systematically connecting them to other categories, validating similarities and relationships and refining categories before arriving at the final twenty themes (Corbin & Strauss, 2008). A weighted analysis of the frequencies of each statement made by subject was also conducted. This included all coded statements across the entire study timeline.

Findings

Post-war socio-economic characteristics

The mean age of the 225 veterans was 26.5 years calculated from the date at which the pension file was opened (Table 1). The majority (85.3%) were married at the time the pension was awarded, whilst 0.9% were divorced and 12.0% were single. Although many returning servicemen struggled to re-establish relationships established before or during the war, the overwhelming majority of marriages survived (Addison, 1985). Despite a peak of 60,190 in 1947, the number of divorces remained at around 40,000 a year until the late 1960s (Hennessy, 2007, p. 130). In this respect, the veteran sample reflects the UK ex-service population of the post-1945 period.

Most veterans in the sample (84%) found employment or became self-employed after demobilization. The sustained growth of the British economy, combined with government spending on reconstruction projects, ensured full employment during the late 1940s and 1950s (Hennessy, 1992, p. 450). Veterans were given preferential access to jobs under the 1944 Reinstatement of Civil Employment Act, which required employers to re-engage former staff who had served in the armed forces for six to twelve months, depending on the length of their pre-war work record (Addison, 1985). Government training centres offered free vocational training for 30 industries with the assistance of employers and trade unions. Funding was made available for those seeking professional qualifications or a university education, though places were restricted. By the end of 1946, 15,000 ex-service entrepreneurs

had been offered resettlement grants of £150 to set up their own companies, together with a three-month course in business methods (Allport, 2009, p. 147).

Service characteristics

Although just under half of the sample had been conscripted into the army, 50.3% had volunteered for military service, including 44 regulars (Table 2). Hence, many of the statements were from veterans who were willing participants in World War Two or who had a long-term career interest in the armed forces.

Over half of the sample (54.2%) were combat soldiers as infantry or tank crews. A further 17.3% had served in the Royal Engineers or Royal Artillery; what today are termed combat support. Hence, 67.6% were in roles which were likely to engage with the enemy and at significant risk of being killed or wounded. Whilst 33 veterans only saw service in the UK, most of the sample (85.3%) had campaigned overseas and were likely to have suffered physical hardships related to climate and disease. Combat veterans are over represented because the Ministry prioritized servicemen who had suffered a breakdown on active service over those who had experienced a psychological disorder in non-combatant roles.

In terms of rank, officers are slightly over represented and private soldiers slightly under represented in the sample. Typically, an infantry company had officers, non-commissioned officers (NCOs) and other ranks in the following proportions: 4.6%, 21.3% and 75% (Anon, 1946, pp. 162, 171). As leaders on the battlefield, junior officers suffered high casualties, which increased their risk of psychological breakdown (Glass, 1947; Jones, Thomas & Ironside, 2010; Beebe & DeBakey, 1952; Beebe & Apple, 1958). In front-line battalions deployed to Normandy, for example, junior officers had a 70% chance of being wounded and 15% chance of being killed (Ellis, 1990, p. 162; French, 2000, p. 148).

Statements and Themes

Many of the 225 veterans offered extended or multiple narratives about their illness. Consequently, the total number of statements (1,301) greatly exceeds the number of subjects. They were grouped into twenty themes and expressed as a percentage of the number of veterans who had stated them (Table 3). Three themes ("anxiety, nerves and depression," "enduring illness attributed to combat exposure" and "illness interferes with the ability to find or keep employment") accounted for 46% of the total number of statements. They were

consistently reported across the fifty-five years of the study, though as veterans came to the end of their working lives in the 1990s, loss of identity/disillusionment DIMINISHED SENSE OF SELF supplanted employment as the third-ranked theme.

Anxiety, nerves and depression

This theme, representing mental illnesses experienced by veterans, was reported by 86% of subjects and was ranked first by number of statements. Although most veterans in the sample recovered sufficiently from the acute effects of battle to return to some form of employment, many continued to struggle with distressing symptoms. Three years after the war had ended, a former infanteer who had been rescued from Dunkirk and later torpedoed on a troopship, reported "my nerves are my main trouble. I can't settle down. I quarrel with people easily". A veteran who had escaped from an Italian prisoner-of-war camp reported in May 1953 that he "only felt comfortable in the open," whilst another former prisoner commented in 1970, "I have difficulty relaxing, am easily upset and ruminate about my experiences". An artillery NCO captured at Singapore and a prisoner-of-war for three years stated in October 1947, "things seem to get on top of me. I don't seem to have the patience I had before, and I worry a lot and have headaches".

However, the pension files also contain narratives of recovery and ten years after the end of the conflict some veterans were reporting an improvement in their mental health. A tank crewman who had been rescued from Dunkirk and then experienced five months campaigning before being captured and held prisoner for four years, observed in February 1952, "I'm beginning to sort myself out". Equally, an infantry NCO who had been captured at Singapore and worked on the Siam railway, reported in June 1954 that his "condition has almost cleared up".

Enduring illness attributed to combat exposure

Reported by 53% of veterans, this theme in part reflected the socio-economic context. Although a claim for a war pension was presumed to succeed unless the Ministry could find compelling evidence to the contrary (King, 1958, p. 25), veterans received a higher payment if the illness was assessed as being directly caused by the war ("attributed"), rather than an aggravation of a pre-existing condition. An infantry NCO who had served in Burma stated in March 1946,"my nerves have been very bad since front-line duty and they have not improved. I want to point out that I was A1 for five years in the army before going into

action". Payments were assessed on a scale of 0% to 100% according to the severity of the illness and the extent to which it prevented the pensioner from earning a living (Cohen, 2001, p. 195). Examining doctors were instructed to reduce payments if signs of recovery were detected or to recommend an increase should the condition worsen. For those in low-paid employment, it was often in the veteran's financial interest to provide evidence of loss of earnings due to greater symptom severity or decreased physical function. An infantry veteran with campaign experience in North Africa and Italy returned to his pre-war work as a builder but in April 1946 stated, "now I find that I am afraid of heights and far from confident on scaffolding. I have tried to conquer this fear but so far my efforts have been unavailing".

"Witnessing death/experiencing loss" was a theme expressed by 28 veterans (13%). Given that 67.6% of the sample had served in front-line roles, it is highly likely that the majority had repeatedly witnessed and occasionally handled dead bodies. In the post-war period, the death of family and friends sometimes served to revive battlefield trauma. One former infantry soldier who had suffered from battle exhaustion in the campaign for northwest Europe commented, "after my wife's death I sit on my own [and] have flashbacks… of the conflict in Normandy in the winter". A former, regular infantry NCO with combat service in North Africa and Italy reported that the death of his mother from leukaemia in 1946 had intensified the "nervousness" he felt "caused by forward action". Exposure to prolonged or intense combat served to sensitize some veterans to civilian deaths in the post-conflict period.

Aerial bombardment was highlighted as a traumatic experience by 12% of veterans. A sergeant in the Royal Armoured Corps identified dive bombing at the siege of Tobruk as the trigger for his breakdown after 15 months campaigning in the Western Desert: "I was in a slit trench which received a direct hit. Whilst in a number of casualty clearing stations, I went through air-raids and, owing to deafness caused by bombing, I began to suffer from nerves". Post-war research found that troops physically and mentally exhausted by repeated bombardment were at increased risk of breakdown (Stouffer et al., 1949, pp. 232-41).

Illness interferes with the ability to find or keep employment

Although the post-war years were a time of full employment, 82 (53%) ex-servicemen reported difficulties sustaining a consistent work record. An infantry veteran who had fought at the Anzio beachhead told his medical board in December 1951, "I had to change my job

three months ago as it was getting too much for me and I was being given greater responsibility". Another former infantry soldier reported in December 1953, "I can't settle down into a position and just drift from one position to another". A veteran with a wife and four children stated seven years after the war that "I cannot improve my ambitions to earn higher wages" because of enduring "weakness". Whilst some may have experienced practical problems in finding paid work, others struggled with the psychological demands of regular employment. A veteran, who had been wounded and then captured when his tank received a direct hit, commented in May 1946, "when the pressure comes on I get in a confused state and frustrated and cannot cope with the proper work etc. and feel of the job. It makes me feel on edge. You cannot concentrate".

Not only did enduring psychological illness limit the range of jobs that were manageable, many veterans also encountered difficulties in the new work environment. They were commonly recruited into junior or entry-level roles and many struggled to adapt to the repetitive nature of clerical or factory work (Allport, 2009, p. 138). Although military service had been hazardous, it came with the compensations of comradeship and the excitement of surviving testing experiences. The loss of friendships and adventure associated with campaigning led some to change jobs repeatedly in a search of a more fulfilling career. An infantry veteran reported in May 1946, "I can't settle down to civvy [civilian] life. I've had four jobs since demobilization".

Diminished sense of self

Extended periods away from home in hazardous roles changed soldiers. Many had witnessed death not only of comrades and the enemy but also of civilians. Some were profoundly affected by these experiences. Five years after the end of the war, a veteran, who had been an army despatch rider, commented that "things have got to such a pitch that even my wife and son doesn't understand the way I carry on". Enduring feelings of being "unsettled" and "unable to enjoy life" were reported in 1956 by an infantry veteran who had been captured at Dunkirk. An ex-serviceman who had been wounded in the evacuation from Dunkirk commented in the post-war period, "I am friendless, suffer from periods of great debility and anxiety… a blighted life". A former artilleryman remained deeply troubled by the death of his comrades; he had asked them to help him lay a signal cable and when a shell fell nearby, they were killed, leaving him untouched. Despite the random nature of bombardment, he took

responsibility for their deaths and believed that "I was being stared at and that I am unwanted".

The diminished sense of self, reported by 35% of veterans, combined with guilt and shame that some experienced, suggests that they would meet the criteria for the new diagnosis of moral injury. This has been defined as participating in or failing to prevent and bearing witness to acts that transgress deeply held moral beliefs and expectations (Litz et al., 2009). The term has its origins in "moral distress" adopted by Andrew Jameton to describe how nurses feel when they are prevented from acting in what they believe to be an ethical manner by institutional regulations (Jameton, 1984). Although characterized by shame and guilt, it is also associated with social withdrawal and self-condemnation.

Sleep problems

Difficulty sleeping was commonly reported by 24% of veterans, attributed in part to repeated nightmares and dreams of combat. It too was an enduring theme. Alistair Urquhart, a former Far Eastern prisoner-of-war, wrote in 2010, "to this day I suffer pain and the nightmares can be so bad that I fight sleep for fear of the dreams that come with it" (Urquhart, 2010, p. 302). Dreams of war leading to interrupted sleep are hypothesized as being a factor that maintain symptoms and possibly inhibit a natural recovery process. Indeed, prazosin, medication used to treat nightmares, has been trialed in US combat veterans on the grounds that by improving the quality of sleep, it could facilitate the effectiveness of therapy for chronic or severe PTSD (Raskind, et al., 2007).

Anger, violent outbursts and irritability

This theme was expressed by 21% of veterans and had an adverse impact on relationships with family, friends, and co-workers. "I get my temper up very, very quick now," reported one veteran who had landed at Normandy and seen two friends killed. He added, "I'm afraid I might kill somebody. I cannot stand by and see injustice or unkindness". Recent studies of veterans have found that anger and irritability are commonly reported symptoms, especially for those with combat-related trauma and disorders (Gonzalez, Novaco, Reger & Gahm, 2016; Raab, Mackintosh, Gros & Morland, 2013; Sayer et al., 2010).

Avoidance of social contact

Avoidance of social contact was reported by 17% of veterans and reflected anxiety in groups but also an intolerance of company. An engineer veteran of the campaign in northwest Europe stated, "I would rather be on my own; I get irritated in a crowd," whilst a former infantry NCO who had fought in North Africa and Italy added, "I am afraid to meet people. I have to avoid people, and this has made me feel inferior". Other ex-servicemen reported that they had difficulty speaking to others: "I have to write down what I want to say." A soldier who had been captured in Greece stated, "when I came home from the war, I could not talk at all and, although it improved for a while, it has been a continual problem". A veteran, who survived a direct hit on his tank that had killed the other three crew members, suffered from an enduring loss of confidence and guilt. Finding himself unable to speak in public, in January 1956 he commented that he had cut himself off from any social activity "for fear of making a fool of himself". Difficulties of communication reflected both an inability to put feelings into words, but also the belief that if he did speak, civilian friends and family would not be interested or would not understand his problems.

Contemporary studies of veterans who suffered from mental health issues during service have shown that they are at elevated risk of social isolation (Mistry et al., 2001; Iversen et al., 2005b). The fact that only 17% of the sample reported this theme may reflect the number and range of civic organizations that existed in the UK during the 1940s and 1950s, offering diverse opportunities for community relationships (Ehrenhalt, 1995; Young & Willmott, 1962). Then, membership of fraternal, sport, ex-service and religious groups was significant compared with the present (Putnam, 1995). Anecdotal accounts illustrated the value of community relationships for veteran transition. Ray Smith, a US veteran, returned to the suburbs of Chicago troubled by his combat experience, where he became a scout leader. "He joined," recalled his wife Millie, because "the pressure was on you to do it" (Ehrenhalt, 1995, p. 215). Community involvement helped Smith to re-integrate and gave him a sense of self-worth and confidence.

Impact of time

Most statements (66%) date from the 1940s, a time when the application process for a pension required the veteran to explain the reason for his illness. Many of the statements from the 1950s reflected continuing issues of causality and changes in the severity of the illness. By the 1960s, the Ministry regarded most disorders as stable, so reviews were conducted less frequently unless the veteran made an additional claim. A rise in the number of statements

during the 1980s and 1990s probably reflected a wider cultural acceptance of post-traumatic illness. PTSD was formally recognized in 1980 and an increasing number of interventions were developed to treat the disorder. UK society in general became more attuned to the psychological effects of war. In particular, the number of statements related to "anxiety, nerves and depression" and to "illness attributed to combat exposure" rose markedly during this period, suggesting an increasingly receptive culture. Further, many of the veterans were approaching the end of their working lives and beginning to reflect on formative experiences. As one former Far Eastern prisoner-of-war remarked in February 1995, "I have more time to think about these things; it's all coming back to me".

In the decades before the recognition of PTSD, Ministry doctors did not always appreciate the long-term effect of extreme or accumulated trauma. In May 1966, for example, a former infantry sergeant applied for a pension as he was no longer able to sustain the workload of a dairy farmer. Suffering from weakness, fatigue, tremor, numbness, pins and needles and persistent anxiety, he relied on help from neighbours to run his farm. The doctor who assessed his application commented on the severity of his wartime trauma, which included evacuation from Dunkirk, being torpedoed on the M.V. *Accra* in the Atlantic on route to west Africa, and service with the Chindits in Burma. In interview, the veteran was recorded as being irritable, "easily upset," "tense and unsure of himself," disliking "anything outside his normal routine," looking "for trouble before it exists" and having restricted social contacts. Diagnosed with "inadequacy (functional disability)," the doctor added that "I cannot relate this to any one of his wartime illnesses, yet it is difficult to deny that the sum of these… might have adversely affected his future heath". In other words, an explicit link was not drawn between an accumulation of severe wartime stressors and an enduring mental and physical state indicative of a post-traumatic illness.

Discussion

In the late 1940s and 1950s, socio-economic conditions in Britain served to ameliorate the challenges of veteran transition. Sustained economic growth, state investment and a wide range of government training schemes saw most ex-servicemen able to find work. Comrades associations multiplied and offered welfare services to ex-servicemen. The size of the armed forces and continuing National Service created a military footprint that had never been larger (Vinen, 2014). Further, air-raids had spread the experience of trauma to emergency responders and much of the civilian population. This should have been a society with an

understanding of military culture and the psychological effects of conflict. Yet, several factors worked against a smooth transition from the armed forces to civilian life. First, a stiff-upper-lip approach to psychological trauma dominated and veterans were discouraged from talking about distressing experiences. There was little provision of out-patient therapy and stigma deterred many from seeking admission to psychiatric units (Jones, 2004). The Civil Resettlement Units that opened for returning prisoners-of-war in summer 1945 treated only 53,000 veterans before they closed in autumn 1946. Clinicians had yet to develop interventions tailored to the treatment of psychological trauma. Hence, most ex-servicemen received little more than symptomatic care from their family doctor. Not until the 1990s, following the recognition of PTSD, was specific trauma therapy developed for veterans.

Statements about mental illness dominated the veteran narrative across the timeframe. The theme of "anxiety, nerves and depression" was consistently ranked as the most common and expressed by 76% of subjects. This was generally attributed to the enduring effects of combat and some veterans continued to ruminate about traumatic events (Table 3). Many experienced a diminished sense of self, combined with feelings of anger and irritability. These changes impacted adversely on personal relationships and led to the avoidance of social contact. Some veterans continued to experience somatic ailments, such as stomach pain and headache, while many were troubled by nightmares and sleep problems.

Research into UK veterans of more recent conflicts has identified similar issues of transition. A study of ex-service personnel with a pension for PTSD who had served in Northern Ireland, the 1991 Gulf War and peacekeeping operations in Bosnia found issues of estrangement, disillusionment and a diminished sense of self (Brewin, Garnett, & Andrews, 2011). Further, a large cohort study of UK veterans who had also been deployed to the Gulf and Bosnia revealed evidence of social exclusion in a context of common mental illness, which arguably had an impact on modest rates of help-seeking (Iversen et al., 2005a). Equally, a study of 1,753 former regulars (with a mean of 17.1 years' service in the forces) found that they had lower levels of social engagement outside work and fewer military social contacts in comparison with serving personnel (Hatch et al., 2013).

A review of UK transition conducted in 2014 by Lord Ashcroft concluded that the greatest difficulties are experienced by "early service leavers, who have served up to four years (but may during that time have completed operational tours in places like Afghanistan),

[and] receive only the most basic support for transition and are most likely to experience unemployment and other problems" (Ashcroft, 2014, p. 14). The review also suggested that the widely-held belief, "the longer a service career, the harder will be the eventual return to civilian life," was unfounded. Other studies have identified early service leavers as being particularly likely to experience significant problems with transition largely because of an association with elevated rates of mental illness (Woodhead et al., 2011; Buckman et al., 2013). Whilst this outcome is not challenged, the attention given to this group of veterans may detract from an equally important finding: those with longer periods of service who have experienced military trauma may also suffer from intractable problems of transition.

Attention in the UK has focused on short-term leavers, in part, because of the inclusive definition (one day in the armed forces) adopted in 2005 for veteran status (Dandeker et al., 2006; Burdett et al., 2013). Of the 18,570 UK service personnel leaving the armed forces in 2009-10, 50.5% were early service leavers. However, 67% of the 9,370 early service leavers had not completed basic training, so had only limited contact with the military (Futures Company, 2013, p. 6). This implies that some of the issues they face during transition relate primarily to their pre-service lives or to vulnerabilities triggered by the induction and training program. By comparison, 7,400 leavers (40%) had served for more than six years, and a further 1,800 (10%) had between four and six years military service, equivalent to the time spent in the armed forces by World War Two veterans. For the UK, the inclusive definition has resulted in a heterogeneous ex-service population, embracing a wide range of military experience. This qualitative study demonstrates that veterans with extensive combat experience are at risk not only of enduring mental illness but also of significant problems adapting to civilian life.

Strengths and Limitations

The study drew on data reported in a consistent manner over six decades. It provided access to veterans with psychological disorders who are often a hard to reach, in part, because of the stigma attached to their illness. Corroborative evidence was collected by the Ministry of Pensions to verify reported stressors and details of military service. Regular boards composed of doctors, many of whom had served in the armed forces, created an opportunity to observe the consistency of narratives over time. In terms of limitations, it is acknowledged that statements were made in the context either of a war pension claim or review of an existing award. As a result, veterans may have overstated their difficulties in the

belief that this would lead to higher payments. However, they were also aware that the pension authorities checked their claims against service medical records and unit war diaries. Subjects in this study are not representative of all UK veterans but were drawn from soldiers who had a recognised psychological disorder and more likely to have found the process of transition challenging.

Conclusion

Time is often evoked as a great healer, and indeed just over 50% of civilian PTSD is resolved within six months, whether treated or not (Creamer & O'Donnell, 2002). However, this finding has not been replicated in military populations. Most veterans exhibit a more resistant or severe form of PTSD such that between 60% and 72% still meet the criteria for the illness after prolonged exposure or cognitive processing therapy (Steenkamp et al., 2015). Our study suggests that a group of core beliefs may inhibit a natural recovery process or sustain troubling symptoms. It also shows that the challenges of transition for veterans with a post-traumatic illness have not changed in their essentials over the last 60 years.

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Table 1. Socio-economic characteristics of the veteran sample

Characteristics	n = 225 (%)
Age (mean ±SD)	26.51 ±7.85

Relationship status	
Married	192 (85.3)
Divorced/Separated	2 (0.9)
Single	27 (12.0)
Not recorded	4 (1.8)
Employment status	
Employed	184 (81.8)
Self employed	5 (2.2)
Unable to work	8 (3.6)
Unemployed	5 (2.2)
Retired	8 (3.6)
Not recorded	14 (6.2)

Table 2. Military characteristics of the veteran sample

Characteristics	**n = 225 (%)**
Recruit status	
Regular	44 (19.6)
Territorial	42 (18.7)

Volunteer	27 (12.0)
Conscript	110 (48.9)
Unknown	1 (0.4)
Unit	
Infantry	106 (47.1)
Armoured units	16 (7.1)
Royal Engineers	23 (10.2)
Royal Artillery	32 (7.1)
Royal Signals	9 (4.0)
Royal Army Service Corps	19 (8.4)
Royal Army Ordnance Corps	9 (4.0)
Royal Electrical and Mechanical Engineers	4 (1.8)
Royal Army Medical Corps	3 (1.3)
Other	4 (1.8)
Rank	
Officers	18 (8.0)
Non-commissioned officers	52 (23.1)
Other ranks	154 (68.4)
Unknown	1 (0.4)
Deployment	
UK service only	33 (14·7)
Deployed overseas	192 (85.3)

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