

“I’m still fighting for the two of us”: How partners of UK veterans construct their experience
of living with combat-related trauma

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A thesis submitted for the degree of Doctorate in Clinical Psychology

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October 2015

Acknowledgements

I would like to thank my research supervisors Dr Leanne Andrews, Dr Syd Hiskey and Dr Susan McPherson for their invaluable advice and support throughout all the stages of this research.

I would also like to thank my partner Alex for his continued encouragement and for helping me to stay motivated over the last three years, and to my Mum and Dad for always supporting me in my endeavours.

I am extremely grateful to Combat Stress and Ripple Pond for supporting this research and, of course, to the women who were generous enough to share their stories with me.

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Abstract

The majority of research in the area of veterans' mental health has been carried out in the United States or the Middle East, has employed a symptoms-based quantitative design, and has been largely focused on the experiences of male personnel. Additionally, most studies have concentrated their efforts on exploring the impact of deployment and trauma on the veteran themselves. This study therefore aimed to explore how partners of UK veterans with posttraumatic stress disorder (PTSD)/symptoms of trauma constructed the impact the condition has on them, the veteran, and their relationship, utilising a qualitative methodology. The study also explored partners' views on the process whereby they themselves had been affected by trauma, and also their perceptions of the way in which UK society views combat-related PTSD/trauma. Participants were 15 female partners of UK military veterans recruited via the organisations Combat Stress and Ripple Pond. Data was collected via semi-structured interviews and was analysed using social constructionist thematic analysis. Five themes were constructed following analysis of the data: "Walking on eggshells": Subduing own emotional and behavioural responses; My wounded soldier or a man behaving badly?; "Being somebody's wife, mother, nursemaid, champion": Partners' attempts at negotiating multiple roles; Heroes don't do the dishes: How constructing veterans as 'heroes' impacts the maintenance of PTSD/trauma and family difficulties; and "The Army were his family": Struggling with the transition to Civvy Street. This study highlighted the importance of considering the veteran as existing within a relational and cultural context, and the need to better support partners of veterans. Strengths and limitations of the study, in addition to further clinical implications of the findings, were identified.

1. Introduction

1.1. Chapter Summary

This chapter outlines the quantitative and qualitative research literature on how veterans and their partners are affected by living with combat-related trauma. It includes an introduction to the United Kingdom (UK) Armed Forces, and the construct of posttraumatic stress disorder (PTSD). It concludes with a rationale for the present study and the aims of the research.

1.2. Current Context of UK Armed Forces

These are times of change for the personnel of the UK Armed Forces. In 2014, the UK Government completed withdrawal of troops from Afghanistan and, at the same time, recent austerity measures have resulted in reductions to the defence budget. This means that the number of Regular Forces personnel are due to be cut by 20,000 by 2020, inevitably leading to redundancies (Fossey, 2012).

The implication of this climate is that there is likely to be an increase in the number of individuals making the transition from military to civilian life. Recent figures from the Ministry of Defence stated that in the period 2011-2012, 21,370 individuals left the Services (Ministry of Defence, 2013), and although this is a smooth journey for many, a small but significant proportion of military personnel will develop mental health difficulties as a result of their deployment experiences. This may either be the reason for their discharge from the Forces, develop as they attempt to adapt to the transition back into civilian ways, or their difficulties may emerge much later in life in accordance with a delayed-onset presentation of PTSD symptoms (National Institute for Health and Care Excellence (NICE), 2005; Andrews, Brewin, Stewart, Philpott, & Hejdenberg, 2009). Indeed, the veterans' mental health charity Combat Stress reported that the average length of time between end of service and veterans

seeking help for symptoms of combat-related distress was just over 14 years (Deahl, Klein, & Alexander, 2011). Numerous reasons for this have been posited in addition to the potential delay in onset of symptoms, including stigma, the ‘macho’ culture of the military, and the inability of civilian mental health services to provide adequate recognition and treatment (Deahl et al., 2011).

1.3. Structure of the UK Armed Forces

The Armed Forces of the United Kingdom operates by a tripartite structure, consisting of the Army, the Navy and the Royal Air Force (RAF). The Army is the largest Force, made up of around 80,000 personnel, and each Force is structured hierarchically using a rank system. Each Force consists of direct combat roles, but also non-combat positions such as medical corps, strategic roles, etc.

In addition to redundancies, personnel may cease their employment with the UK Armed Forces due to medical discharge. For all Forces (between 2008-2013), the most common reason for discharge was musculoskeletal disorder or injury, with mental and behavioural disorders being the second most common reason for medical discharge for all three branches (which were at a rate of 11%, 14% and 18% for the Navy, Army and RAF respectively). The most prevalent conditions that led to discharge were depression, PTSD and adjustment disorder (Ministry of Defence, 2013).

1.4. How Veterans May be Affected by Their Combat Experience

1.4.1. Psychiatric symptoms. Although PTSD is the condition that is likely to come to mind first when thinking about military mental health, in contrast to most preconceptions, it is not necessarily the most prevalent complaint experienced by veterans. Indeed, in their cohort study of 9990 UK Armed Forces personnel who were either currently serving or had previously served in Iraq or Afghanistan, Fear et al. (2010) found that 4% of their sample

reported probable PTSD, whereas 19.7% had symptoms of common mental health diagnoses (i.e. depression, anxiety), and 13% indicated alcohol misuse. Likewise, in their sample of vulnerable UK veterans (i.e. those scoring *caseness* on the General Health Questionnaire (Goldberg et al., 1997) and/or those unemployed four or five years after leaving the Forces), Iversen et al. (2005) found that 43.8% met criteria for a psychiatric diagnosis following assessment with a structured interview. Of these, the most common psychiatric diagnosis was depression (53.4%), while PTSD was much less common (16.3%).

Where PTSD is present, its comorbidity with other psychiatric diagnoses is high; for example, in their sample of 114 veterans with PTSD, Brewin, Garnett, and Andrews (2011) reported that 97% also met criteria for depression, 32.5% for possible alcohol abuse and 38.6% for definite alcohol abuse. Various demographic factors have been indicated as increasing risk for developing PTSD, such as lower rank, leaving service early, having a physical injury, and childhood adversity (Jones et al., 2013a). These factors were found to be related to developing PTSD, whereas deployment to Iraq or Afghanistan in itself was not. However, occupying a combat role during deployment to these areas was associated with PTSD (Jones et al., 2013a). This means that there is likely to be a subsection of individuals who are more vulnerable to developing later difficulties, even before they commence in their military role.

However, although there are suggestions that PTSD is not the most reported psychiatric diagnosis across the veteran population as a whole, there is evidence to indicate that it is more prevalent within the clinical population of UK combat veterans – perhaps due to the presence of organisations such as Combat Stress which provide intervention specifically for PTSD (MacManus & Wessely, 2013). This finding, in addition to the potential detrimental impact of PTSD/trauma on the veteran and their family (discussed later on in this chapter), provides another reason why it is worthy of further research attention.

1.4.2. Psychological and practical adjustment to civilian life. In addition to psychological distress as a result of combat experiences, the transition from military to civilian life can also be an extremely emotionally demanding time for the veteran and their family. Deahl et al. (2011) and Figley (1993) highlighted that the technological advances in transportation meant that it was entirely possible for service personnel to be in direct combat operations one day, and at home with their family one or two days later. This meant that they may have entered family life from a highly adrenalin-producing situation, into one which ideally requires the ability to be calm and thoughtful. Recently in the UK however, personnel are required to engage in periods of ‘decompression’ following combat operations – involving a period of downtime with military colleagues who have served the same operation. The aims of decompression are multiple and include: celebration and appreciating the work which has been completed; providing a safe environment for service personnel to informally and formally talk about and process their tour experiences; and to allow for some closure and relaxation before returning to base (and for many, returning to their families) (Hacker Hughes et al., 2008). The rationale for this is that it will aid reintegration and provide a supportive environment which minimises the risk of developing mental health issues as a result of the deployment, and also allows early identification of any psychological issues. The use of decompression in the UK Armed Forces has been debated for a number of years, with commentators initially citing the lack of evidence of its efficacy as a reason why it should not be universally implemented (Hacker Hughes et al., 2008). For the last few years though, a short period of decompression (around 36 hours at a base in Cyprus) has been mandatory for UK troops. Although it has been deemed unfeasible to carry out a randomised controlled trial into the effectiveness of this approach, Jones, Burdett, Wessely, and Greenberg (2011) employed a survey-based design to gain some information on the impact of the intervention from the point of view of 11,000 UK personnel who had been deployed to Iraq or

Afghanistan. They reported that only 21% of individuals were keen to attend decompression beforehand, but 91% rated it as being helpful at the end of their time in Cyprus - although those who initially did not want to attend were less likely to find it beneficial. Additionally, non-commissioned officers, those who held a combat role, and individuals who had previously completed a period of decompression were also less likely to indicate that it had been helpful. This highlighted ongoing challenges in relation to ensuring that the approach best meets the needs of all personnel who attend, and helping those who are reluctant to engage – often because they are desperate to return to their families as soon as possible – to see decompression as being a vital part of the tour (Jones et al., 2011). Qualitative data from Burdett, Jones, Fear, Wessely, and Greenberg (2011) similarly indicated that personnel would appreciate a more flexible approach to decompression, allowing more unstructured time to move away from the formality of the Armed Forces, and that psychoeducational briefings should be more tailored to each individual. A later study by Jones et al. (2013d) suggested that decompression was associated with improved mental health outcomes and lower alcohol misuse, particularly for military personnel who participated in low or medium levels of combat exposure, although there was no evidence that it led to better readjustment back into civilian life. These findings are significant both for veterans and their families, as a successful period of decompression has the potential to improve the veteran's emotional wellbeing, which in turn would be likely to benefit those close to them, despite their being limited evidence for its influence on the process of transitioning back to family life.

In relation to this transition, the veteran may find that they cannot simply join where they left off as their family may have adapted to their absence, perhaps reassigning roles or becoming less reliant and dependent on them (Nelson & Wright, 1996). This potentially poses an additional challenge in terms of adaptation from a culture where roles and responsibilities are clearly defined, and respect and honour are attributed firmly in relation to

the rank system (Deahl et al., 2011). Some veterans report finding domestic life dull and unexciting in relation to the highly stimulating environments they have experienced, and find that their children do not relate to them in the same way as before their deployment (Figley, 1993). The socio-cultural context of each conflict can also influence the nature of the transition, with it potentially being more difficult if the veteran believes society is unappreciative or critical of their efforts (Deahl et al., 2011).

1.5. Defining the PTSD Construct

1.5.1. Diagnostic criteria. One reason for the different views of PTSD, say to other diagnostic labels like depression, may be due to it being the only disorder within the *Diagnostic and Statistical Manual of Mental Disorders (DSM; currently 5th edition; American Psychiatric Association, 2013)* which includes suggestion as to the aetiology of the condition. The *DSM-5* (APA, 2013) is a United States-based, categorical classification system of mental disorders, used to aid the diagnosis of psychiatric conditions by providing a common language. There are numerous criticisms though of the *DSM-5*'s (APA, 2013) approach to understanding emotional distress, namely lack of reliability and validity of the categories, cultural bias, pathologisation of normal human responses, and undue influence from pharmaceutical companies who benefit from increasing medicalisation (Aboraya, Rankin, France, El-Missiry, & John, 2006).

Some of these criticisms relate to the fact that the description and categorisation of mental disorders changes over time, with every revision of the manual. This was indeed the case with the PTSD diagnosis, which received one of the most significant revisions following the publication of the most recent edition of the *DSM* (5th edition; APA, 2013), which replaced its predecessor, the *DSM-IV-TR* (American Psychiatric Association, 2000). In the *DSM-IV-TR* (APA, 2000) PTSD was categorised with the anxiety disorders, as there was deemed to be conceptual overlap between the anxiety-based symptoms of PTSD (avoidance,

hyper-arousal, re-experiencing) and some of the symptoms of general anxiety disorder, social anxiety and specific phobias (Houston, Webb-Murphy, & Delaney, 2013). However, evidence from clinical research suggested that some individuals were more likely to struggle with depressive symptoms following a traumatic event rather than anxiety (Friedman et al., 2011). This contributed to the shift in thinking towards it being seen as more appropriate to focus on common aetiology (i.e. having experienced a trauma) rather than symptomology (Friedman et al., 2011). A new chapter was therefore introduced into *DSM-5* (2013), entitled 'Trauma and stressor-related disorders' in which PTSD was placed.

With the introduction of *DSM-5* (APA, 2013), there were also changes to the specific diagnostic criteria for PTSD. This included greater clarification of Criterion A, which stated in *DSM-IV-TR* that the individual would need to have been exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. The revision added greater specificity to this, by giving examples of traumatic events and also indicating that the trauma may be experienced indirectly as well as directly, such as through repeated exposure to details of traumatic events (such as paramedics, mental health professionals, etc.). This change seems important when considering the potential for secondary traumatisation of partners and family members of veterans. The earlier edition also stated that the person must have experienced a subjective reaction of intense fear, helplessness or horror, but this was removed following research evidence that not all individuals who go on to develop PTSD (such as combat veterans) necessarily have this subjective response at the immediate time of the trauma (Friedman et al., 2011).

As with the other diagnostic categories outlined in the *DSM-5* (APA, 2013), an individual will need to meet a range of criteria for a PTSD diagnosis to be given. These also received some revision between *DSM-IV-TR* (APA, 2000) and *DSM-5* (APA, 2013), most notably the addition of Criterion D: negative alternations in cognitions and mood (including

persistent and distorted negative beliefs about the self, others and the world, and a distorted sense of blame for what happened) (Houston et al., 2013). This was deemed important to include as research into treatment approaches, such as cognitive behavioural therapy, suggested that successful intervention for PTSD involves re-evaluating these negative beliefs (Houston et al., 2013). Therefore in summary, at this point in time, an individual seeking a diagnosis of PTSD would have to meet the following criteria: in addition to having experienced a trauma, the diagnosis will be considered if the person reports symptoms that map onto the following: Criterion B: Intrusions; Criterion C: Avoidance; Criterion D: negative alterations in cognitions and mood; Criterion E: alterations in arousal and reactivity. These need to have been present for at least one month, be causing significant impairment to the person's life (e.g. in terms of social, occupational functioning), and not be due to medication, substance misuse, or another illness (Criterion F, G and H). The publication of the *DSM-5* (APA, 2013) also saw the addition of a dissociative subtype to the PTSD diagnosis category, for which individuals receiving this diagnosis would be presenting with significant symptoms of depersonalising or derealisation, in addition to meeting the other necessary criterion. Delayed onset PTSD is specified as being cases where the full range of symptoms emerge six months or more after exposure to the trauma (see Appendix A for a more detailed version of the *DSM-5* (APA, 2013) and *DSM-IV-TR* (APA, 2000) PTSD diagnostic criteria).

These changes had implications for researchers and clinicians alike, as the available standardised tools of assessment and diagnosis of PTSD required updating and additional research to explore their psychometric properties (Houston et al., 2013). As the vast majority of the quantitative research papers cited in this thesis utilised measures based on *DSM-IV-TR* (APA, 2000) diagnostic criteria, this will be the edition that is referred to from here onwards. The *DSM-IV-TR* criteria (APA, 2000) were also most likely to be those used to diagnose the

majority of veteran partners of the participants in this study (for individuals who had received a diagnosis of PTSD).

1.5.2. Recommended approaches to psychological intervention for PTSD. Within England, the National Institute for Health and Care Excellence (NICE) recommended that trauma-focused psychological intervention (such as trauma-focused cognitive behavioural therapy (CBT) or Eye Movement Desensitisation Reprocessing (EMDR)) should be the first treatment offered for PTSD (National Institute for Health and Care Excellence (NICE), 2005).

The approaches adopted by trauma-focused CBT, and some other dominant treatment models, are informed by the dual representation theory of PTSD (Brewin, Dalgleish, & Joseph, 1996) and the cognitive model of PTSD (Ehlers & Clark, 2000). The dual representation theory suggests that intense emotion at the time of a trauma leads memories of the event to be processed differently from other autobiographical memory, which results in the memories being fragmented, incomplete and not located in a particular place or time within the person's narrative of their life. The intense emotion experienced at the time of the event leads the memory to be stored in the amygdala rather than the hippocampus (where less potent autobiographical memories are stored), meaning that the person is not so able to consciously recall, and therefore process it. This also means that amygdala-based memories are triggered easily and by a wide range of cues, leading to problematic re-experiencing symptoms. This links to the person's sense that the traumatic event is happening again, with the same intensity as at the original time of the trauma. This theory indicates therefore that psychological intervention should support the processing of amygdala-based traumatic memories into the person's life narrative (and therefore encouraging storage in the hippocampus), hence meaning that they are less likely to be triggered outside the person's awareness and cause flashbacks.

Central to the cognitive model of PTSD (Ehlers & Clark, 2000) is the theory that difficulties arise when an individual processes information in a way that maintains a sense of current threat. This leads the person to employ cognitive and behavioural coping strategies in an attempt to control the threat, but which have the unintended consequence of maintaining their PTSD symptoms. These are likely to include avoiding internal (e.g. thoughts) or external (e.g. places) reminders of the event, which means that these behaviours maintain PTSD by preventing further elaboration of the trauma memory or allowing the person to reappraise the situation and modify any unhelpful trauma-related cognitions they hold. Similar to the dual representation theory, this model suggests that psychological intervention should focus on elaborating and integrating the trauma memory within the person's life story, in addition to addressing problematic appraisals of the trauma, and encouraging the person to stop any unhelpful cognitive and behavioural strategies that are maintaining their PTSD (Ehlers & Clark, 2000; Speckens, Ehlers, Hackmann, & Clark, 2006).

However, Figley and Figley (2009) argued that the reliance on individual-focused models of treatment (e.g. CBT, Eye Movement Desensitisation and Reprocessing therapy (EMDR)) is a significant limitation of current treatment approaches, and that systemic methods have a crucial role to play in addressing the relational impact of trauma. Indeed, they challenged the idea that successful treatment is defined by the reduction of individual PTSD symptoms, when it is possible that significant interpersonal difficulties will still remain.

1.5.3. Critique of the construct. Some critics have argued that the focus on PTSD and military mental health has had a detrimental impact on the recognition and treatment of the breadth of emotional distress or psychological adjustment reactions experienced by ex-service personnel (Walker, 2010; Deahl et al., 2011). This “preoccupation with PTSD” may also have led to over-diagnosis, with a range of varying experiences with differing causes being lumped together as one disorder (Deahl et al., 2011, p. 204). It is difficult to truly know

whether emotional distress is linked directly to traumatic war experiences, or whether it existed before the individual entered their military life (Deahl et al., 2011). Indeed, the development and expression of trauma symptoms is complex and is likely to be a result of a wide range of life experiences, contexts and influences, which has led some to suggest that their military experience is a “convenient scapegoat” that means they do not have to consider more painful reasons for their distress (Deahl et al., 2011, p. 204).

1.5.4. The social construction of PTSD. The diagnosis of PTSD is understood by some as being highly politicised, at least historically, as it was introduced into the third edition of the *DSM* in 1980 following the United States’ involvement in the unpopular Vietnam War. Summerfield (2001, p. 95) suggested that the “invention” of PTSD came at a time in history where it served a particular purpose for its recipients and society. For the first time, military personnel returned from conflict and were branded villains rather than heroes, called “baby killers” and blamed for the atrocities that had occurred (Summerfield, 2001, p. 95). He suggested that the label of PTSD meant that veterans were viewed in line with the preferable moral stance of victim rather than oppressor, and it allowed society to reconstruct the nature of their attitudes towards the returning forces. This in turn redirected blame towards the US military, rather than focusing on the individuals’ roles in the actions they may or may not have carried out in Vietnam. Furthermore, Jones and Wessely (2007) highlighted that the construct of PTSD has been used as a political tool by anti-war lobbyists who have used it to demonstrate that conflict has a long-lasting psychiatric effect on the men and women who partake in it.

In terms of the UK, the way that traumatic stress is understood has also been informed by our country’s experience of warfare, and the psychological consequences observed in some individuals following their involvement in these conflicts. The First World War is cited as being a pivotal time-point for the way in which traumatic stress was conceptualised,

specifically the work of C.S. Myers and W.H.R. Rivers with soldiers who had symptoms of *shellshock*. Previously thought of as being the result of a concussion due to a physical injury to the head or spine, these clinicians posited the idea that emotional shock alone was enough to produce symptoms of trauma, which led to important changes in the nature of interventions provided for these young men (Young, 1995). Consequentially, these ideas contributed to a shift in the dominant degenerate narrative of mental illness popular during that period – and for the first time, society realised that emotional distress and traumatic life events could contribute to psychological difficulties in previously healthy individuals, including men who were robust enough to service in the Armed Forces (Howorth, 2000). Indeed, by the end of World War II, and following their continued treatment of servicemen involved in frontline combat, British clinicians concluded that “all servicemen, no matter how carefully selected, well-trained or led, had a breaking point” (Jones & Wessely, 2007, p. 169).

Moving onto present day, there appears to be an emerging critical narrative about reasons why people seek the diagnosis, whether it be malingering for financial gains or to avoid the stigma associated with ‘non-military’ mental health issues, like depression. This has led commentators to suggest that “it was rare to find a psychiatric diagnosis that anyone liked to have but posttraumatic stress disorder was one” (Summerfield, 2001, p. 96), and there is some research evidence to suggest that some service personnel may seek the diagnosis, or distort the true nature of their symptoms, to try and obtain maximum compensation (Frueh, Gold, & de Arellano, 1997).

1.6. The Need for Contextually-Specific Research into Combat-Related Trauma

Following on from this, there is an argument that there is value in studying the impact of war-related trauma in the context in which it is experienced, as PTSD is history-, culture- and event-specific (Afuape, 2011). This is particularly relevant to the current study due to the recognition that there is a paucity of research into the experience of UK military families

(Fossey, 2012). This section considers similarities and differences with some other countries and cultures in relation to combat-related trauma.

1.6.1. Comparisons between the UK and US Armed Forces. Extrapolations are commonly made between the UK and USA, although there is an argument that research findings do not necessarily generalise between these nations. There are stark differences between the US and UK in terms of their military policy - US Armed Forces tend to spend a longer time on each deployment and less time between each tour (Hotopf et al., 2006) - and the structure of mental health care provision. Indeed, Richardson, Frueh, and Acerno (2010) indicated prevalence estimates for the rate of PTSD in US Iraq military veterans as being between 4-17%, whereas the estimate for their UK counterparts was 3-6%. Hotopf et al. (2006) noted key differences between US and UK Iraq veterans that may account for these differences, such that the US cohort were younger, less experienced, of lower rank, and were exposed to greater risk during their deployment. , Richardson et al. (2010) argued that the socio-political contexts of each country may have played a role in the prevalence and presentation of PTSD between countries, for example the need for a diagnostic label to gain financial compensation, disability benefits, and pay-outs from health insurance companies.

More recently though, this finding has been challenged. Sundin et al. (2014) directly compared prevalence data from one US and one UK study that explored mental health outcomes post-deployment to Iraq. They found that the differences in prevalence of PTSD were largely explained by variations in combat exposure between the two countries, and therefore rates of PTSD were consistent across the two groups once this had been taken into account. However, some differences between nations remained even when the data analysis controlled for combat exposure: specifically, levels of alcohol misuse and aggressive behaviour. They suggested cultural and policy differences in relation to alcohol consumption may explain this finding. For example, they posited that the UK is more likely to implicitly

acknowledge benefits of moderate drinking (such as unit cohesiveness, relaxation) and that there is no formal arrangement for alcohol-related counselling following an incident, unlike in the USA Armed Forces.

1.6.2. Comparison with prevalence rates in other Western nations. Richardson et al. (2010) compared prevalence rates of combat-related PTSD reported in a number of research studies, which focused on veterans of a range of conflicts and from a variety of nationalities. They found that for Canadian veterans, lifetime estimates of PTSD were reported at 7.2%, rising to 10.3% for those who completed three or more tours, indicating similar prevalence rates as to their US counterparts. The Australian studies suggested that prevalence rates differ depending on the particular tour or conflict, as Australian veterans of the Vietnam War were reported to experience a 21% lifetime rate of PTSD and 12% current, whereas Gulf War veterans experienced a 5.4% rate of PTSD 10-15 years post-conflict. Richardson et al. (2010) however highlighted that methodological differences between studies (such as recruitment strategies, method of assessing for PTSD, and length of time since deployment) mean it is difficult to draw firm conclusions about variations in prevalence.

Although studies based in Israel were not included in the review by Richardson et al. (2010), key differences in the structure of the Israeli Defence Forces (IDF) and the socio-political context mean that findings would not necessarily translate to UK veterans and their families. Specifically, Israel operates mandatory conscription into the IDF for most citizens over the age of 18, and also the focus of military intervention is commonly about defending home soil, rather than being deployed elsewhere. It could be argued that these factors may influence how the Armed Forces are perceived by society, and in terms of PTSD, the extent to which someone might be exposed to reminders of the trauma and the sense of being under attack.

1.7. Literature review: Quantitative Research

1.7.1. Narrative review of the quantitative research literature. As the primary focus of the present research was on qualitative findings, it was deemed adequate to carry out a systematic narrative review of the quantitative literature rather than a full meta-analysis. This was because this literature review aimed to describe the breadth of the body of literature (i.e. impact of PTSD on partners, children and family units as a whole, individually and in terms of relationships), rather than to combine the findings of studies to answer a specific question or to provide an estimate of effect size (Uman, 2011). However, a systemic approach was taken to identifying and appraising the literature to be included in the narrative review, as outlined below. Only quantitative literature was included in this section, as relevant quantitative literature was included in a meta-synthesis (see section 1.9).

1.7.2. Search strategy. To obtain the studies for review, a systematic search of electronic databases (PsychArticles, Medline with Fulltext, CINAHL Complete) was carried out, using the following search terms in various combinations and with use of truncation where needed: post-traumatic stress; post-traumatic stress disorder; PTSD; trauma; secondary trauma; secondary trauma; vicarious trauma; secondary traumatic stress disorder; veteran; military; partner; family; wife; wives; husband; boyfriend; girlfriend; spouse; relationship; couple; partnership; marriage; dyad; children; family. Studies were included in the review if 1) the focus of the study was on some element of partners' or family's experiences of living with a veteran with combat-related PTSD/trauma and 2) the design was quantitative. The search covered the time period of 1980 to 2014. Theoretical papers and non-published dissertations/theses were excluded, and qualitative studies were put aside for inclusion in the meta-synthesis. Internet searches and reviews of the reference lists of selected papers were conducted to ensure that other relevant studies were not overlooked. These papers were sorted into categories (e.g. secondary traumatisation; impact on communication; relationship

with children, etc.) to provide the structure for the review and to identify any additional search terms with which to return to the electronic databases. All papers were included that focused specifically on secondary traumatisation or PTSD symptoms in partners of veterans, and to cover the breadth of other relevant research (e.g. impact on children; family dynamics) review papers or meta-analyses in these areas were prioritised. Where these were not available, papers were chosen for inclusion that best summarised the body of research, for example seminal papers, those which gave more recent updates, and those which had results which both agreed with or challenged prior findings. This was in line with the guidance for narrative reviews outlined by Green, Johnson, and Adams (2006).

1.8. Impact on Partners of Veterans: Summary of quantitative literature.

Importantly, it is not solely the individual who is affected by the psychological impact of combat exposure, as a significant proportion of veterans will be returning to live with their families. There is a significant body of evidence from other countries to suggest that partners are affected by living with a veteran who is experiencing an aversive reaction to trauma/PTSD. Spouses have been found to experience high levels of stress, depression (Manguno-Mire et al., 2007), symptoms of PTSD, anxiety (Westerink & Giarratano, 1999), adjustment disorders, relationship dissatisfaction (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Goff, Crow, Reisbig, & Hamilton, 2007; Lambert, Engh, Hasbun, & Holzer, 2012), hostility, suicidal ideation (Manguno-Mire et al., 2007), parenting difficulties, chronic pain (Koić et al., 2002), lower ratings of their satisfaction with life (MacDonell, Thorsteinsson, Bhullar, & Hine, 2014), burnout/caregiver burden (Solomon, Dekel, Zerach, & Horesh, 2009; Klarić et al., 2010), paranoia and loneliness (Jordan et al., 1992; Nelson & Wright, 1996; Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005a; Dirkzwager, Bramsen, Ader, & van der Ploeg, 2005; Frančičković et al., 2007; Klarić et al., 2010; Weinberg, 2011). The following section explores some of these areas in more detail.

1.8.1. Secondary Traumatic Stress. Since the end of the Vietnam War, researchers have been interested in the concept of Secondary Traumatic Stress (STS) (also known as secondary traumatisation or Secondary Traumatic Stress Disorder (STSD)) whereby individuals close to the primary trauma survivor experience their own trauma reaction (Figley, 1983, 1986). The term secondary traumatisation shares conceptual overlap with other terms used in the literature: vicarious traumatisation, compassion fatigue (in the case of healthcare professionals), counter-transference, and burnout, although there are arguably differences in the speed of onset, type of symptoms and nature of relationship with the person experiencing the trauma (Figley, 1995).

1.8.2. Critique of the Secondary Traumatic Stress construct. The idea of STS, however, has not been understood in the same way by all researchers, leading to conceptual differences in how it has been applied across the field. Some researchers (e.g. Frančišković et al., 2007) regard it as being analogous to the *DSM-IV-TR* (APA, 2000) definition of PTSD, whereby the partner experiences a trauma and suffers re-experiencing, avoidance and hyper-arousal as a result. Alternatively, other researchers have conceptualised STS as potentially involving a much broader range of emotional and relational distress, such as low mood, anxiety, OCD and somatisation (e.g. Arzi, Solomon, & Dekel, 2000), leading to a more inclusive, general definition. Renshaw et al. (2011) explored this quantitatively by exploring the symptoms of 190 wives of male service members/veterans, and found that the majority of women were experiencing general distress (e.g. feeling tense and dissatisfied with life), although a sub-section were experiencing symptoms in line with a PTSD-consistent presentation. Although these two positions are conceptually different, these authors also noted that the term secondary traumatisation is often used in the trauma literature to refer to both constructs (Galovski & Lyons, 2004; Renshaw et al., 2011). Furthermore, in their recent integrative review of 14 studies focusing on the mental health of partners of veterans, Yambo

and Johnson (2014) found that three key themes emerged: secondary traumatic stress, caregiver burden and general psychological distress. They also highlighted the overlap between concepts, adding that constructs such as compassion fatigue and vicarious trauma are also used interchangeably within the literature. This is potentially a limitation as each construct contains within it different assumptions as to the process whereby partners are affected by living with trauma.

1.8.3. Position of the present researcher in relation to STS. For the purposes of this literature review, studies adopting both the *DSM-IV-TR* (APA, 2000) consistent and more inclusive definitions of secondary traumatic stress have been included. This means that both have been regarded as important in terms of understanding how veterans' partners may be emotionally impacted by living with combat-related trauma. This is also in line with the current study's own methodology and research questions, which aimed to investigate how partners constructed the way they, their veteran partners, and their relationships were affected by trauma, therefore taking an explorative stance. The current study also was not limited to individuals whose veteran partners had been formally diagnosed with PTSD, therefore to have focused solely on a *DSM-IV-TR* (APA, 2000) based definition would be inconsistent with this approach. However, the present researcher regards the different conceptualisations of STS as being a potential limitation in this field of research, and holds the view that researchers should explicitly state their perspective when publishing their findings.

1.9. Secondary Traumatic Stress: Quantitative Research

The differences in how STS is conceptualised has had an impact on the choice of measures that researchers have selected to explore the construct, with some remaining close to the *DSM-IV-TR* (APA, 2000) definition and others including items that asked about broader, related difficulties (e.g. alcohol use, relationship issues).

Secondary traumatisation has been explored within a European sample, using a tool that only included items directly relating to the re-experiencing, avoidance and arousal diagnostic criteria. Frančišković et al. (2007) measured symptoms of secondary traumatisation experienced by the wives of veterans who fought in the Croatian war of 1991-1995. Their chosen measure (a modified version of the Indirect Traumatisation Questionnaire (Havelka & Krizmanić, 1995)) mapped onto the *DSM-IV-TR* (APA, 2000) conceptualisation of PTSD, whereby the Criterion A stressor was the wives having knowledge of their husbands' trauma. They found that although the vast majority of wives experienced symptoms of secondary traumatisation (53 of the 56 women), only 22 of 56 met the criteria for STSD (which paralleled the criteria required for PTSD diagnosis). They also found that a longer length of time being married, and the wife being unemployed, were significant predictors of the women's level of STS. It should be noted though that STSD is not a formally recognised psychiatric diagnosis, and assuming that the symptoms exactly mirror those of PTSD may not be reliable or valid. The study also made the assumption that exposure to tales of the veteran's primary traumatic experience was the trigger which resulted in their partner's distress. As discussed later in this chapter, there are numerous ideas about the mechanisms of secondary traumatisation, and hearing about a loved one's traumatic experiences is only one of those which has been proposed.

Some researchers have chosen to not explore STS as a separate construct, and instead used PTSD measures to explore symptoms experienced by partners of veterans with a PTSD diagnosis. Within the Middle East, Al-Turkait and Ohaeri (2008) explored PTSD symptoms in four groups of Kuwaiti wives, categorised by the extent of their husbands' war experience. They found that 28.4% of wives met criteria for probable PTSD, as assessed by the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979) and the Clinician Administered PTSD Scale (Blake et al., 1995), with higher rates of symptomology reported by those whose

husbands had been prisoners of war and/or involved in direct combat. Although 28.9% of husbands also met criteria for PTSD, there was no correlation between the prevalence of diagnosis in husbands and wives. This perhaps challenged the notion of secondary traumatisation as, in this study, the likelihood of the women meeting PTSD diagnostic criteria was not linked to their husbands' symptomology. The authors noted some possible cultural factors that may have explained this finding, such that the Kuwaiti war was fought on home ground, meaning that some women experienced direct exposure to threat themselves. Indeed, they also reported that women who were living in Kuwait at the time of the conflict were more likely to meet PTSD criteria.

The more common finding within the literature is that partners of veterans with PTSD symptoms are likely to experience similar symptoms themselves. This was the case in Dirkzwager et al.'s (2005) study of Dutch former peacekeepers and their partners and parents. In addition to increased PTSD symptoms (as measured by the *DSM-IV-TR* (APA, 2000) based Self-Rated Inventory for PTSD (Hovens, van der Ploeg, Bramsen, & Reuling, 2000), partners of peacekeepers with PTSD reported more problems with sleep, physical health, social support and their marital relationship. There was no significant effect for parents of peacekeepers suggesting, at least for this study, that being in a couple relationship was associated with increased difficulties. A limitation of this study – as with most of the other research in this area - was that its cross-sectional design meant that it was not possible to conclude whether the partners' difficulties preceded, or developed after, the onset of the peacekeepers' PTSD (Dirkzwager et al., 2005; Fairbank & Fairbank, 2005).

The effects of living with PTSD for partners, as well as the PTSD sufferer, are potentially long-lasting. Klarić et al. (2012) reported that partners of war veterans from Bosnia and Herzegovina still experienced significant symptoms of emotional distress 12 years after the war. In their sample, 40.3% of female partners of veterans with PTSD met

criteria for the diagnosis themselves (as measured by the *DSM-IV-TR* (APA, 2000) based Harvard Trauma Questionnaire (Allden et al., 1998)), whereas the rate was only 6.5% for the control group of partners of veterans without PTSD. The PTSD group were also more likely to suffer from physical health problems (29.9%) and to report symptoms of other psychiatric diagnoses. The authors also reported that the partners of veterans with PTSD had, on average, lower educational achievement and socio-economic status than the women who were in relationships with veterans who did not have the PTSD diagnosis. Although the authors cited that this finding may be due in part to different recruitment strategies employed for the experimental (via clinical sample of veterans) and control groups (women volunteering to take part), it nonetheless reminded us that families are likely to be struggling with wider social issues that impacts their experience of living with trauma, and perhaps increases their risk of developing difficulties in the first place.

1.9.1. Studies employing a broader definition of STS. Ahmadi, Azampoor-Afshar, Karami, and Mokhtari (2011) investigated the prevalence of STS in Iranian spouses of veterans who served in the Iran–Iraq (1980–1988) conflict, by administering the Mississippi Scale for Combat-Related PTSD (Spousal Version) (Keane, Caddell, & Taylor, 1988). They reported that all of the spouses indicated STS symptoms, with 49% scoring in the moderate range and 51% the severe range on this measure. They also found that the severity of the veterans' PTSD symptoms predicted the spouses' level of STS, as did how long the veterans' had experienced their symptoms. The rate of spousal STS in this study was much higher than reported by other researchers. The authors noted that possible reasons for this may have been the very high rate of physical injury in their sample (75.6%), and cultural factors. They suggested that the belief that their husbands were injured during the conflict for divine reasons perhaps meant that the women had a heightened sense of duty to care for their husbands and to compensate for the roles within the family that the men were not in a

position to fulfil. This provided additional support for considering the interaction of sociocultural factors in the expression and impact of trauma. One additional reason for the very high prevalence of STS symptoms may have been that the measure employed in this study aligned with a more inclusive definition of PTSD (and therefore STS), asking questions about alcohol use and relationships as well as symptoms that mapped onto *DSM-IV-TR* (APA, 2000) criteria. This linked again to the importance of establishing the definition of STS and how it is being measured within a specific research study, before comparing with others.

In Israel, Arzi et al. (2000) measured symptoms of emotional distress, caregiver burden, and separation-individuation in three groups of veterans' wives. Wives whose partners had been diagnosed with PTSD or post-concussion syndrome (PC) reported higher levels of burden and emotional distress – including symptoms of depression, anxiety, obsessive-compulsiveness, psychoticism, and somatisation – than the control group of women whose veteran partners did not have a diagnosis of PTSD or PC. Other studies have noted the high rates of caregiver burden in partners of veterans with PTSD, and the link between burden and psychological distress (Beckham, Lytle, & Feldman, 1996; Calhoun, Beckham, & Bosworth, 2002; Dekel, Solomon, & Bleich, 2005n). Arzi et al. (2000) cited their findings as providing support for the presence of secondary traumatisation but, unlike other studies, they did not directly measure PTSD or STS symptoms experienced by the women, but rather used measures of general distress. This again linked into one of the key debates in the literature: whether STS is best described as a discrete disorder, which parallels the *DSM-IV-TR* (APA, 2000) PTSD construct, or whether it is a term which describes a more general emotional distress experienced by those living with someone who has been traumatised (Renshaw et al., 2011).

1.9.2. Impact on relationships. In their meta-analytic review of quantitative research into the relationship between PTSD and partners' perceived relationship quality and PTSD and partners' distress, Lambert et al. (2012) reported that PTSD was associated with a combined small to moderate negative impact on partners' assessment of their relationship quality. They also reported that, although there was variation between individual studies, on the whole PTSD had a moderate impact on partners' psychological outcomes, in that it was associated with greater levels of emotional distress, caregiver burden and secondary trauma. Interestingly, they noted that effect sizes were larger for military couples than the general population. To explain this finding, the authors referred to research which suggested that PTSD in military populations is more associated with anger and aggression than it is in civilian cases, which is likely to affect couple functioning.

An earlier systemic review of the literature carried out by de Burgh, White, Fear, and Iversen (2011) resulted in 14 US-based studies of the impact on spouses of their partners' deployment to Iraq or Afghanistan, and found that those returning with PTSD symptoms were at greater risk of impaired marital health (de Burgh et al., 2011). However, unlike the results in Yambo and Johnson (2014)'s review, they reported that findings in the literature were inconsistent in terms of whether deployment and the military partner's combat exposure was detrimental to civilian spouses' wellbeing and relationship satisfaction. They also noted a number of methodological limitations that are common across quantitative studies in this area. This included using brief screening measures rather than validated clinical tools, taking into account only one person's report of family/marital functioning, and the over-inclusion of Army and Marine personnel limiting generalisation to other branches of the Armed Forces. These criticisms are relevant to other studies in this area by researchers in other countries, and are not limited to US-based research.

Melvin, Gross, Hayat, Jennings, and Campbell (2012) explored couple functioning in relationships where at least one partner was a military veteran. As with previous research, they found that posttraumatic stress symptoms (PTSS) were associated with impaired couple functioning. However, they also included a measure of resilience within their design, and found that resilience acted as a moderator between PTSS and couple functioning. That is, partners and veterans with high resilience scores reported better couple functioning, even in cases where their individual PTSS were high. The authors suggested therefore that building resilience should be a key area of therapeutic intervention for military couples. Likewise, Mikulincer, Florian, and Solomon (1995) explored potential buffers to relationship distress, reporting that wives of veterans with combat stress reaction who indicated greater levels of intimacy with their spouses experienced better health six years after the war, and less negative emotions immediately following the war. Therefore intimacy, as well as resilience, potentially protects partners from some of the relational effects of living with trauma.

1.9.3. Partners' perceptions of veterans' ability to cope. There is some suggestion that the expression of difficulties in partners may be in part moderated by their perception of how the veteran is coping (De Burgh, White, Fear, & Iversen, 2011). Renshaw, Rodrigues and Jones (2008) reported that spouses of veterans were more likely to experience greater severity of PTSD symptoms themselves if they felt that their partner was denying or minimizing the extent of their own PTSD. Additionally, Weinburg (2011) found that spouses who perceived their husbands as adopting an emotion-focused coping style (e.g. ventilation of emotion, disengagement or avoidance), rather than a problem-focused coping style (e.g. active problem-solving, planning and finding solutions), in relation to their traumatic experience reported a higher level of distress. In fact, it was the women's perceptions of their husbands' coping styles that significantly predicted the extent of their own distress, more so than the women's own coping styles. These findings suggested that the dynamic between the

couple may be pertinent in understanding how trauma is experienced and adapted to within family relationships.

1.9.4. Emotional numbing and avoidance. Some studies have explored in more detail about what aspects in particular make living with trauma difficult for spouses to manage, and what relationship challenges it is associated with. Emotional numbing, that is: an inability to feel and express positive emotions and feeling distant from others, is often reported by partners as being the most difficult element (Cook et al., 2004). This maps onto the avoidance cluster of symptoms outlined in the *DSM-IV-TR* (APA, 2000) definition of PTSD. This is perhaps crucial to the health of relationships as emotional disclosure and connection is often tied to a sense of intimacy.

Likewise, Goff, Crow, Reisbig, and Hamilton (2009) explored PTSD and more general trauma symptoms in 45 male US soldiers who were deployed to Afghanistan and/or Iraq and their female partners. They found that soldiers' level of avoidance accounted for 13% of partners' secondary traumatic stress symptoms, which was therefore the cluster of symptoms that were most detrimental to the wellbeing of the women. This supported other research findings that individual trauma symptoms (such as avoidance) do not only affect the person who directly experienced the stressor, but also couples' relationship functioning and mental health of partners.

In contrast, Hamilton, Nelson Goff, Crow, and Reisbig (2009) explored the impact of female civilian partners' PTSD symptoms on their own and their military partners' relationship satisfaction. In addition, a measure of trauma history was also completed for both partners. Although it was hypothesised that avoidance would be the most detrimental to relationship satisfaction, this was not supported by their quantitative study. Instead, they found that for the women themselves, their husbands' re-experiencing symptoms were most

associated with lower relationship satisfaction; whereas for the men, their wife's hyper-arousal was the most difficult factor. They suggested that one explanation for this may be that the husband's subsequent trauma in effect triggers the women's own trauma histories and re-traumatises them, leading to higher levels of re-experiencing and arousal symptoms – thus potentially leaving both partners feeling emotionally unsafe within their relationship.

1.9.5. Attachment style and other pre-existing characteristics. In addition to the notion that trauma experienced by one individual can have an impact on others close to them (Figley, 1983, 1986), the research acknowledges that the non-veteran partner will also bring with them their own attributes and life experience that are likely to influence the couple's response to trauma (Nelson & Wright, 1996). Dekel (2007) reported that, in a sample of Israeli wives of veterans and wives of prisoners of war, anxious or avoidant attachment styles were associated with higher levels of distress. However, an unexpected finding was that greater distress was related to higher levels of posttraumatic *growth* for these women, as was the case across the whole sample. The author reflected upon past research about how extremely traumatic situations, such as those experienced by Holocaust survivors or those exposed to terrorist attacks, can lead to positive outcomes to the extent that the more traumatic the experience, the more growth is reported (Tedeschi & Calhoun, 1996). Similarly, Ein-Dor, Doron, Solomon, Mikulincer, and Shaver (2010) explored the theory that attachment processes impacted the development and maintenance of secondary traumatic stress in a sample of Israeli couples, where one partner was a veteran of the Yom Kippur War (with one group of *veterans only* and another group of *prisoners of war*). Their analyses suggested that individuals with higher levels of attachment anxiety experienced greater severity of STS or PTSD symptoms. Additionally, wives' STS symptoms were associated with their husbands' level of attachment anxiety, but – contrary to the study's hypotheses, wives' attachment anxiety was not linked to the severity of their partners' PTSD symptoms.

In terms of avoidant attachment, Ein-Dor et al. (2010) found that this was only associated with severity of PTSD/STS symptoms where the veteran had been a prisoner of war, under prolonged and extremely traumatic conditions. The authors alluded to the idea that avoidant styles of relating may be adaptive in some traumatic situations, but that this is likely to break down in cases of chronic and/or intense trauma, such as being held captive and tortured. They also noted that in their POW sample, wives' avoidant attachment style was related to higher severity of intrusive PTSD symptoms in their husbands. This lends credence to the idea that the attachment-related behaviours of each individual within a relationship can impact the experience of the other partner, and vice versa, in this case perhaps suggesting that the wife's avoidant style meant that she did not encourage her husband to discuss the emotional aspects of his trauma, therefore meaning that his intrusive symptoms continued. This is in line with the dual representation theory, which posits that avoidance of trauma memories leads to unwanted intrusions (Brewin et al., 1996).

Additionally, the vast majority of research has explored symptoms of psychological distress either during or immediately after deployment, or when the serving individual has left the Forces and become a veteran. Erbes, Meis, Polusny, and Arbisi (2012) explored the mental health of U.S. National Guard soldiers and their spouses one to two months *before* deployment. Spouses reported significantly higher depression rates than did their military partner, which was at a level above that in psychiatric morbidity studies of the general population. This suggests that there may be variables that pre-exist within couple relationships, which have an important influence on how the couple adapts to combat-related trauma. In this sense, not all the difficulties can be said to be *post*traumatic or as a result of *secondary* trauma.

Another important consideration is the impact of the trauma history of the civilian partner. During their research into developing the Couple Adaptation to Traumatic Stress

model (see below for more detail), Goff and colleagues noted that a high proportion of spouses/partners of soldiers reported traumatic events in their own lives (Goff & Smith, 2005). This led to further exploration by Hamilton et al. (2009) who found that *civilian* spousal trauma and PTSD symptoms were associated with lower relationship satisfaction for both parties. Indeed, Melvin et al. (2012) explored secondary traumatic stress within their sample of female partners, but also collected data on the women's previous trauma histories. They reported that 34% of women met criteria for STS; however, once their previous trauma information was included in the analysis, only one woman still met criteria for STS. This meant that the rest of the women had experienced traumatic events in their own lives that may have accounted for their posttraumatic symptoms.

1.10. Literature review: Qualitative meta-synthesis

1.10.1. About meta-synthesis. Meta-synthesis is an increasingly recognised method of bringing together qualitative research within a particular field. It has been argued that this method needs to become more prevalent if qualitative research is to influence health and social care policy on a similar scale as meta-analysis (Walsh & Downe, 2005; Thomas & Harden, 2008). Qualitative research studies are well placed to provide detailed insights into some element of individuals' lives, whether it be (depending on their epistemological position) the experiences or phenomenology of its participants, or how individuals construct their realities. However, the process of meta-synthesis is not without its critics. Key arguments are that qualitative research is not generalisable in the same way as some quantitative designs, and as the researcher is central to the process of data collection and analysis the findings of a particular study should not be reanalysed out of their original context (Walsh & Downe, 2005; Thomas & Harden, 2008). These are valid concerns, but the need to increase the utility of qualitative research findings still remains.

1.10.2. Procedure. The research discussed in this introduction to date has been quantitative, therefore this meta-synthesis provided a detailed review of the qualitative literature available on this area. As the current study is qualitative in design, applying a meta-synthesis to understanding the findings of previous studies in the area was deemed appropriate. To obtain the studies for this meta-synthesis, a systematic search of electronic databases (PsychArticles, Medline with Fulltext, CINAHL Complete) was carried out, using the following search terms in various combinations and with use of truncation where needed: post-traumatic stress; post-traumatic stress disorder; PTSD; trauma; veteran; military; partner; family; wife; wives; husband; boyfriend; girlfriend; spouse; relationship; couple; partnership; marriage; dyad. Studies were included in the review if 1) the focus of the study was on some element of partners' experiences of living with a veteran with combat-related PTSD/trauma and 2) the design was qualitative. Theoretical papers and non-published dissertations/theses were excluded. All papers within the time frame of the electronic databases were included (approximately 1980 to present day), as interest in secondary traumatic stress and related concepts grew following the end of the Vietnam War (1975). However, internet searches and reviews of the reference lists of other relevant papers provided a way to ensure that earlier papers (and any additional publications not found via the database searches) were not overlooked. This resulted in ten research studies which were included in the meta-synthesis, which are described in Table 1 below.

1.10.3. Sample. The ten papers included in the meta-synthesis were published between 1988 and 2014, were from five different countries, and generally employed a phenomenological or descriptive approach to understanding the data. Seven of the papers focused on partners of Vietnam War veterans, and all of the participants were female partners or wives, aside from one study that interviewed both members of the couple dyad. The

sample sizes ranged from four to 76, with those employing interview-based data collection method having sample sizes of 23 or less (and an average of 11 participants).

1.10.4. Analysis. Noblit and Hare's (1988) method for data analysis and synthesis was adopted for the purpose of this review. This involved seven steps which were progressed through, in a non-linear fashion. The first three steps involved deciding on the area for study, finding the relevant papers and reading them thoroughly. The steps key to the analysis process involved firstly identifying the key themes and concepts in each paper, by staying close to the interpretations of the original author. Relationships between the themes were also examined, and noted where they contradicted or agreed with each other. It is advised that any apparent contradictions should be carefully included in the analysis, rather than omitted or minimised, as this is where deeper knowledge about a phenomenon can arise (Walsh & Downe, 2005). This was also the case for the next step: *reciprocal and refutational translation*, where commonalities and differences between papers were translated into new themes. This was followed by synthesis of translations, where new knowledge was gained from the analysis which was more than that contained within each individual paper alone.

1.10.5. Findings. The following themes were identified as relevant to the experiences described by the participants across the ten papers.

1.10.5.1. A picture of PTSD in family life. This theme applied to the studies that allowed participants to speak more generally about their experience, rather than asking specifically about a particular element (i.e. post-traumatic growth (McCormack, Hagger, & Joseph, 2010) or social connectedness (Vagharseyyedin, 2014)). The women described in some detail what was most difficult about living with PTSD, with anger, hyper-arousal, aggression, flashbacks, withdrawal, possessiveness, and unpredictable behaviour from their partners repeatedly mentioned as detrimental to family life (Frederikson, Chamberlain, & Long, 1996; Lyons, 2001; Outram, Hansen, MacDonell, Cockburn, & Adams, 2009).

Table 1
Summary of studies included in the meta-synthesis

<u>Study</u>	<u>Sample</u>	<u>Country</u>	<u>Conflicts</u>	<u>Method</u>
Dekel et al. (2005a)	9 wives. Age, $M = 45.2$.	Israel	Veterans of Israeli Defence Forces	Semi-structured focus group Phenomenological
Frederikson et al. (1996)	5 European New Zealander wives. Age range, 41 – 47 years. 2 divorced. Relationship length, $M = 18.4$ years.	New Zealand	Vietnam War veterans	Template approach: use of analysis guide developed after review of accounts
Gerlock, Grimesey, and Sayre (2014)	23 couples where male was a veteran. Age range, 27 – 83 (veteran) & 24 – 71 (partner). Relationship length, 2 – 45 years.	USA	Vietnam ($n = 14$), Afghanistan/Iraq ($n = 5$), Persian Gulf ($n = 3$), World War II ($n = 1$)	Semi-structured interviews Partners interviewed separately Grounded Theory
Lyons (2001)	10 women. Age range, 44 – 51. 3 separated. Length of marriage, 14 – 29 years.	USA	Vietnam War veterans	Semi-structured interviews Phenomenological
Maloney (1988)	6 female partners. Age range, 31 – 38. 1 not currently in relationship.	USA	Vietnam War veterans	Semi-structured interviews Phenomenological
McCormack et al. (2010)	4 women. Age range, 56 – 65 years. Length of relationship, 17 – 35 years.	Australia	Vietnam War veterans	Semi-structured interviews Interpretative Phenomenological Analysis
Nir, Ebadi, Khoshknab, and Tavallaie (2013)	12 wives. Age range, 37 – 50 years.	Iran	Iranian veterans	Focus group Content analysis
Outram et al. (2009)	76 women. Age range, 47.5 – 72.4, $M = 57.3$. Length of relationship, $M = 30$.	Australia	Vietnam War veterans	Focus groups
Vagharseyyedin (2014)	14 wives. Age range, 39 – 55 years, $M = 45.5$. Length of marriage, 8 – 27 years, $M = 21$.	Iran	Iranian veterans	Semi-structured interviews Content analysis
Verbosky and Ryan (1988)	23 female partners. Age range, 24 – 38 years. Length of relationship, 1 – 19 years.	USA	Vietnam War veterans	Analysis of weekly therapy group content and process notes

In four of the studies, the women explicitly mentioned that their relationships had become abusive, either emotionally, verbally and/or physically (Maloney, 1988; Frederikson et al., 1996; Lyons, 2001; Outram et al., 2009) which was seen as being a consequence of

their partners' combat experiences. However, the women in Maloney's (1988) study spoke about having been in past violent relationships and there also being abuse within their families of origin, with some resignation that violence and alcoholism was a male inevitability. This linked to the review of quantitative studies above, which suggested that there are potentially complex reasons underlying partner choice, such as attachment history and previous exposure to traumatic events. These factors are likely to influence the experience of living with combat-related PTSD for both partners.

Some of the studies described a process whereby the participants engaged in an active process of meaning-making to try and make sense of the impact that PTSD was having on their lives and relationships. It was crucial for their own wellbeing for the women to have some explanation - which often meant hearing more about traumatic combat-related events - or else they tended to assume responsibility themselves for the difficulties:

Women reported having believed for many years that the problems they experienced were normal marital conflicts. This, in part, was due to the blame and manipulation directed towards the women, fostering a belief they were responsible for his problems... Once the women had an explanation (albeit sometimes after 30 years) for the psychological problems and antisocial behaviour of the men, they felt it was easier to accept. (Outram et al., 2009, pp. 131-132)

1.10.5.2. Physically present but emotionally absent. Of particular note was the difficulty caused by living with a partner who was physically present within the family, but who greatly struggled to connect with family life on an emotional basis. This was mentioned specifically in four of the studies (Frederikson et al., 1996; Dekel et al., 2005a; Outram et al., 2009; Nir et al., 2013). The women in Dekel et al.'s (2005a) study described this as being a lonely place and that they felt personally unfulfilled. Communication was also cited as problematic in terms of it being limited to practicalities (such as providing the partner with

food or medication) (Nir et al., 2013), or asymmetric - with power, dominance and control belonging to their husbands. As with the findings from quantitative research, emotional numbing and avoidance were particularly difficult from the women's point of view, and they felt that there was no real emotional connection or partnership in their relationships (Frederikson et al., 1996). These emotional numbing symptoms were understood as being detrimental to communication within couple relationships, with the resulting silence leading the women to become hyper-vigilant to their veteran partners' moods and behaviours, or to become more demanding of the veteran to try and encourage disclosure (Gerlock et al., 2014). Interestingly, this approach to trying to overcome the lack of communication was seen as momentarily worsening the veteran's PTSD symptoms, reminding us of the dynamic interplay of trauma symptoms and behaviour within couple relationships: "Partners' attempts to communicate could be experienced by veterans as aggression, or as "triggers"" (Gerlock et al., 2014, p. 350).

1.10.5.3. Necessary shift in behaviour, roles and relationships. This theme included the changes participants noted in their marital/partner relationship, strategies they employed to manage their situation, and how they were repositioned within their family unit. The women reflected that their situations now meant that they had a significant caring role, leading some to state that they felt more like a mother than a wife, and that they treated their husband like a child due to his dependency (Maloney, 1988; Dekel et al., 2005a; Outram et al., 2009). The women in Maloney's (1988, p. 135) study described this as if their Vietnam veteran partners were stuck in an earlier developmental stage, which the authors suggested meant they had not had the opportunity to grow into healthy and adaptable men:

The women said that their partners were and still are frozen in adolescence and relate to them as needy children rather than as adults...jolted out of adolescence, they had imposed upon them a violent separation from all they had previously understood to be

moral and humane. They were robbed of any sane guidance, any credo which would have led to a firmer and healthier identity, and were instead denied the process of individuation. (Maloney, 1988, p. 139)

Although this dependence eventually took its toll, it was also cited as a reason why the women stayed in the relationships and did all they could to protect their partners' from future pain (Maloney, 1988). Additionally, their husbands being positioned as highly dependent inevitably led to the women 'over-functioning' and taking on almost all roles within the household, including those which had previously been the responsibility of their partners (Maloney, 1988; Lyons, 2001; Nir et al., 2013; Vagharseyyedin, 2014)

Various strategies were employed by the women to make everyday life more manageable. This ranged from 'walking on egg shells' and deflecting blame onto one's self (Verbosky & Ryan, 1988; Outram et al., 2009), setting boundaries with their partner to maintain some sense of their own self (Dekel et al., 2005a), keeping the peace and reducing the need for their partner to have to deal with any stressful situations (Frederikson et al., 1996), over-functioning, repressing own feelings of anger, avoiding conflicts, denial and keeping secrets from other family members, and over-immersing self in work (Lyons, 2001). One study which focused also on later stages of the journey of living with PTSD suggested that the women began to use more productive ways of self-care, like seeking support, to help them cope effectively with their situation (Lyons, 2001).

1.10.5.4. Impact on own emotional and physical health. The studies discussed the effects living with trauma had on the partners' own health (Maloney, 1988; Lyons, 2001; Outram et al., 2009; McCormack et al., 2010; Nir et al., 2013). This included physical health problems such as stomach ulcers, cardiovascular issues, skin complaints, migraines (Outram et al., 2009), and a range of mental health difficulties and emotional concerns: PTSD, depression, agoraphobia, fear, anger, worry, sleep problems, somatisation, self-blame,

hopelessness (Maloney, 1988; Lyons, 2001; Outram et al., 2009; McCormack et al., 2010; Nir et al., 2013). Linking to the concept of secondary traumatisation, women in two of the studies described feeling ‘infected’ by their partners’ PTSD (Dekel et al., 2005a; Nir et al., 2013). They felt that the boundary between their own and their partners’ emotional experience became blurred, meaning that they themselves were affected psychologically.

Some women mentioned having to take psychotropic medication as a result (Outram et al., 2009; Nir et al., 2013). Although many of the complaints mirrored those likely to have been also experienced by their partners, the mechanism for their distress (i.e. the reason *why*) was not on the whole explicitly explored. The assumption tended to be that the experience of living with the effects of trauma was the cause of their distress, rather than there being a contribution from their prior life experiences or hearing about their husbands’ traumatic events. The exception to this was in Maloney’s (1988) study, where the women reported having nightmares of Vietnam and reacting to similar triggers as their husbands. This is consistent with Figley’s theory that empathising with the traumatic experiences of a loved one can lead to secondary traumatisation (see next section).

1.10.5.5. Society’s lack of understanding and tolerance. Four studies referred to the views of society and how these are often stigmatising towards the veteran and their families. Interestingly, these were two studies carried out in Iran (Nir et al., 2013; Vagharseyyedin, 2014) and the two involving partners of Vietnam War veterans (Frederikson et al., 1996; McCormack et al., 2010). This supported the idea mentioned earlier in this introduction: that research of combat-related trauma should be conflict- and culture-specific. The Iranian women particularly spoke about being resented by non-military families for being seen to be privileged by the State, and also that neighbours kept their distance due to their husband’s condition. For the Vietnam veterans, the women acknowledged that the way society had treated their partners on their return from the unpopular war had been extremely difficult for

them to deal with. This had also affected their friendships and family relationships as veterans were not forgiven for what they had been involved in , such that “political opposition becomes personal opposition to the men who went to Vietnam; the veterans are caught in a political position they cannot change in the same way others can” (Frederikson et al., 1996, p. 65).

The women in both these studies, though, found this to be a way for them to channel their anger, aiming it at the Government and society rather than themselves.

1.10.5.6. Growth from adversity and realising the positives. This theme was apparent to some degree within the majority of studies, with the women being able to reflect on ways in which they – and their husbands - had grown and developed as a result of their difficult experiences. This included realising the positive aspects of their relationships, reflecting that they had become a more caring and compassionate person, and admiring the strength of their husbands (Dekel et al., 2005a). Others had developed self-acceptance, acceptance of others, become less judgemental and realised their personal strength (McCormack et al., 2010). A sub-theme within this area was the women feeling like they were acting in line with their moral values. Particular cultural reasons appeared to influence how important this was for women, as it was cited by the women from the Israeli and Iranian studies. For example, the women in Dekel et al.’s (2005a, p. 34) study reported a sense that they had made a moral and conscientious commitment to their husbands, and:

this value is intensified because of the damage that the husbands suffered. Because the man performed a mission for the country, it becomes his wife’s social responsibility to care for him.

Similarly, others spoke about national and cultural values and their pride in caring for their husbands, whilst some women referred to their religious beliefs as to why they remained committed (Nir et al., 2013; Vagharseyyedin, 2014). Included in this was their view that God

had a plan for their lives and that adversity was a test that had been presented to them, and they would be rewarded for their sacrifice (Vagharseyyedin, 2014). These beliefs were not limited to Middle Eastern cultures, as the Australian women in McCormack et al. (2010)'s study also spoke about feeling more in touch with their spirituality and the idea that both pain and growth can occur from adversity.

1.10.6. Summary. The body of qualitative research provided a rich understanding of how partners were affected by living with combat-related trauma. Some of the themes were similar to those reported within the quantitative literature; however, this meta-synthesis provided an insight into how participants made sense of their experiences, the impact they had on their relationships and sense of self, and the dynamic processes involved in living with trauma.

1.11. Research into the Impact on Families and Children

Of course, partners are not the only civilian member of a veteran's family. Researchers have focused on the impact that living with PTSD or trauma can have on the wider family dynamic, including children, and how the family unit as a whole adapts to their situation. Importantly, veterans themselves have reported significant concerns about the quality of their relationships with spouses/partners and children, and in one study, indicated a preference for family-focused treatment rather than individual input (Khaylis, Polusny, Erbes, Gewirtz, & Rath, 2011). This suggested that the area of family functioning and impact of PTSD and deployment on children is a key concern for returning veterans.

1.11.1. Domestic violence. Domestic violence has been researched within veteran populations and is deemed to occur at a higher rate in families where the veteran partner has been diagnosed with PTSD (Jordan et al., 1992; Galovski & Lyons, 2004; Taft et al., 2005). Unsurprisingly, women in these violent relationships with veterans rate their marital satisfaction and family functioning as lower than do women in non-violent relationships

(Chrysos, Taft, King, & King, 2005). It is also well-recognised that domestic violence can have a harmful psychological impact on children. Clarke et al. (2007) reported that children exposed to aggression inflicted on their mother by their veteran father displayed higher levels of internalising and externalising behaviour problems, which was partly mediated by their mother's distress.

1.11.2. Psychological impact on children. Since the atrocities of the Holocaust, there has been an interest in the intergenerational transmission of trauma and whether it is possible for the offspring of trauma survivors to be psychologically impacted by their parents experience, despite not directly living through it themselves. Davidson and Mellor (2001) explored this phenomenon within a sample of children/young adults whose fathers were Australian Vietnam War veterans with PTSD, compared with samples of similarly aged civilians, and those with veteran fathers without PTSD. They reported that the young people whose fathers had PTSD did not score higher on a measure of PTSD symptoms or lower on self-esteem measures, in comparison to the other groups of young people. The group with PTSD-diagnosed fathers did however rate their family's ability to solve problems and to display and react appropriately to emotional expression as much lower. Similarly, the children in Westerink and Giarratano's (1999) study who were living with veteran fathers with PTSD rated higher levels of conflict within their families, but did not display elevated levels of psychological distress in comparison to their peers. These findings perhaps suggested that a general sense of dysfunction within a family is a more pertinent issue for the young people, rather than them experiencing PTSD symptomology themselves.

On the other hand, Herzog, Everson, and Whitworth (2011) did find evidence for a moderate association between PTSD symptoms in Iraqi soldiers (who were also fathers) and secondary trauma symptoms in their children. This was particularly the case for internalising behaviours in the children, such as withdrawal, anxiety and depression symptoms, as rated by

their parent. Herzog et al. (2011) also found evidence to support their hypothesis that secondary trauma symptoms in the civilian spouse would mediate the relationship between the soldier's PTSD symptoms and their child's symptoms of secondary traumatisation. This highlighted the way in which all family members may potentially be impacted by combat-related trauma through their relationships with each other.

Although Dekel and Goldblatt's (2008) literature review on the intergenerational transmission of trauma reported that some studies indicated children of veterans with PTSD displayed increased behaviour problems, anxiety, and aggression; research findings on the whole were inconsistent. A limitation of this body of research was that participants tended to be recruited through clinical settings, therefore less is known about the emotional health of children whose veteran parent had not engaged in mental health treatment (Dekel & Monson, 2010).

1.11.3. Parenting. Also cited within Dekel and Goldblatt's (2008) review was the observation that some veterans (not necessarily limited to those with PTSD) displayed an authoritarian parenting style, leading to controlling and demanding relationships with their children. Enmeshed and over-involved parent-child relationships have also been reported (Galovski & Lyons, 2004). Similar to couple relationships, emotional numbing and avoidant PTSD symptoms were found to be most detrimental to the parent-child relationship (Ruscio, Weathers, King, & King, 2002; Samper, Taft, King, & King, 2004; Dekel & Goldblatt, 2008), perhaps because availability and emotional receptivity are key ingredients of *good enough* parenting. Additionally, behaviourally avoidant PTSD symptoms were also likely to interfere with family life, for example through lack of involvement in household tasks, children's activities, and socialising with friends and family (Dekel & Monson, 2010). Once more, these findings provided an important reminder that many veterans return to a family

where there are particular role expectations placed upon them, and that PTSD is likely to provide an additional challenge to them being able to fulfil these effectively.

1.11.4. Family functioning. There is evidence to suggest that living with PTSD negatively impacts multiple areas of family functioning, as rated by both veterans and their spouses. Jordan et al. (1992) reported that around 60% of veterans with PTSD and their partners indicated medium to high levels of marital problems, that there were more incidences of violence in families living with PTSD, and that a third of children of veterans with PTSD had behavioural difficulties within a clinical range. Although these were all higher than the level of problems experienced by families of veterans where PTSD was not present, the authors reminded us that not all of the families living with PTSD were unhappy and that a number reported feeling able to cope and generally satisfied with their family functioning, at least at times.

In common to factors influencing the quality of couple and parent-child relationships, the avoidance cluster of PTSD symptoms has also been found to be particularly linked to impaired family functioning (Evans, McHugh, Hopwood, & Watt, 2003; Galovski & Lyons, 2004). This can mean that the veteran is less likely to self-disclose, be open to meeting the emotional needs of their family members, or willing to communicate and explain what they are struggling with (Galovski & Lyons, 2004). Instead they may withdraw, become angry, or both, which in turn means that incidents within the family cannot be discussed and understood in a healthy way (Galovski & Lyons, 2004). Indeed, emotional disclosure was found to moderate the relationship between PTSD symptoms and parental functioning (Solomon, Debby-Aharon, Zerach, & Horesh, 2010). Without this ability to communicate openly, the veteran himself may feel a sense of a loss of his role or place in the family, and that he is seen as the cause of all conflict.

1.12. Mechanisms of Secondary Traumatization: How Do Partners Become Affected?

Several possible mechanisms for this transmission have been proposed, and are discussed in turn below.

1.12.1. Communication. Maloney (1988) suggested that the process involves family members overly empathising with the individual and their experiences, so much so that they begin to internalise the individual's feelings, memories and beliefs as their own (Nelson-Goff & Smith, 2005; Dekel & Monson, 2010). An alternative mechanism is that indirect exposure to the traumatic event, for example by the veteran talking in detail about what happened to them, can act as the trigger for the partner developing a stress reaction. Evidence for this position can be derived from Campbell and Renshaw's (2012) study which suggested that increased communication about a traumatic event by veterans with PTSD was related to higher psychological distress in their spouses, although this was not the case when veterans' symptoms were below the clinical cut-off for PTSD. The nature of communication may also be affected: Dekel, Enoch, and Solomon (2008) noted that couple relationships where the veteran had also been a prisoner of war were characterised by lower levels of self-disclosure and higher verbal abuse, whilst Campbell and Renshaw (2013) found that emotional disclosure was negatively associated with relationship satisfaction for both partners and veterans. Baddeley and Pennebaker (2011) also observed that an expressive writing exercise was helpful in reducing veteran's aggressive behaviour and improved their marital satisfaction, but this effect was not observed in their partners. These findings lend some credence to the idea that the way in which traumatic events are communicated interpersonally is likely to impact partners of veterans, potentially causing or increasing their level of psychological distress.

1.12.2. Caregiver burden. Living with trauma often leads to each partner changing their behaviour within the relationship. Gilbert (1997) discussed the presence of *over-*

responsibility and over-functioning in the partner who did not directly experience the trauma, which can take the form of them trying to protect the individual from any further harm, and to lessen the roles they are expected to fulfil within the home. As well as potentially maintaining the individual's difficulties, it is likely to also become extremely draining for the partner taking on the caring/responsible role. Indeed, partners of veterans with PTSD have been found to report high levels of caregiver burden (e.g. Calhoun et al., 2002), which may be responsible for some of their emotional distress.

1.12.3. Figley's Trauma Transition Model. Figley (1995) has written widely about the impact of trauma on the family system and has proposed different ways whereby this takes place. Figley (1995) surmised that individuals within a system can become traumatised in four ways. These included: 1) simultaneous trauma, whereby all members become traumatised by an event at the same time; 2) vicarious trauma, where one member is/was in a potentially life threatening situation and other family members imagine the trauma that might have happened; 3) intra-familial trauma (or abuse) is where the traumatic event is as a result of the direct action of one family member to another; 4) chiasmal or secondary trauma, when the traumatisation initially experienced by one member appears to infect others within the system, who begin to show their own emotional distress and trauma symptoms. Figley stated that it is the last category that is most relevant to families of veterans with PTSD.

Gilbert (1997) discussed the difference between distal and proximal secondary traumatic stress, and the potential impact on spouses. Distal STS is related to vicarious traumatisation, a result of the family member imagining what their loved one might be going through in the absence of regular contact or information to either confirm or deny their worries. In this sense, their uncertainty and powerlessness leads them to fill in the gaps in their minds. On the other hand, proximal STS refers to the effects of living with someone who is extremely traumatised, which can lead to burnout, coping with symptoms such as

depression, sleep problems, anger and flashbacks. According to this description, it appears that Figley and Gilbert subscribed to a more general understanding of secondary traumatisation, rather than one which overlaps with *DSM-IV-TR* (APA, 2000) criteria.

In terms of *why* family members become traumatised, similar to Maloney (1988), Figley stated that family members' emotional closeness puts them both in the position of being effective healers of trauma, but also at risk of developing symptoms themselves. Indeed, he concluded that: "their strength as well as their Achilles' heel is empathy" (Figley, 1986, p. 48).

1.12.4. The Couple Adaptation to Traumatic Stress (CATS) model. Nelson-Goff and Smith (2005) adopted Figley's conceptualisation of secondary traumatic stress and incorporated it into their systemic theory of trauma in couples. They argued that although there is support for the secondary traumatisation hypothesis within the literature, its limitation is that it does not fully explain the interaction between individual trauma symptoms and marital problems, or the specific mechanisms underlying how trauma impacts interpersonal functioning. This prompted them to develop the Couple Adaptation to Traumatic Stress (CATS) model (Nelson-Goff & Smith, 2005), which suggested that the couple's experience of trauma relies on an interaction between: both individuals' current level of functioning (including behavioural, cognitive, emotional and biological symptoms); their own predisposing factors (such as previous trauma history, age and resources); and couple functioning (attachment, power, communication, conflict, roles, etc.). Importantly, they stressed that there is a bidirectional relationship between each factor, which means that each have the ability to influence the expression of trauma symptoms in the other. For example, it may be that the veteran within the couple is experiencing difficulties with physical contact or communication following his trauma, which results in his partner withdrawing and feeling depressed by her husband's avoidance of intimacy, which in turn maintains and worsens his

difficulties. This model captures some of the complexity that has been discussed throughout this introduction in terms of the elements that may influence how trauma is experienced within a couple, such as communication style, previous trauma histories, attachment style and behaviours, and resilience.

1.13. Summary and Rationale for the Current Research

In conclusion, the majority of research in the area of veterans' mental health has been carried out in the United States (Fossey, 2012) or the Middle East, has employed a symptoms-based quantitative design (Ray & Vanstone, 2009), and has been largely focused on the experiences of male personnel (Galovski & Lyons, 2004; Fossey, 2012). Additionally, most studies have concentrated their efforts on exploring the impact of deployment and trauma on the veteran themselves (Nelson & Wright, 1996; Goff & Smith, 2005). However, this means that there is currently a lack of research into how civilian partners may be affected by living with a veteran who is experiencing a significant reaction to trauma, particularly from a UK perspective. Indeed, in a recent report, Fossey (2012) writing for the UK's Centre for Mental Health, identified a need for research attention to be focused on family members of the UK military, and highlighted that the emotional and psychological needs of spouses and partners have often been neglected. This introduction and review of the literature has demonstrated that partners themselves, and the relationship between them and their veteran partner, can be significantly affected by living with trauma in a number of ways. Therefore, there is a strong rationale for exploring this qualitatively within a UK sample of partners which as yet, to the best of the current researcher's knowledge, has not been carried out.

1.14. Aims and Objectives

This study therefore aimed to answer the following research questions:

1. How do partners of veterans with PTSD/trauma symptoms construct the impact the condition has on them, the veteran, and their relationship?
2. For partners who feel they have been personally affected by the veteran's PTSD/trauma, how do they construct the process whereby this occurred?
3. How do partners think that UK society views combat-related PTSD/trauma, and how do they construct the implications of this for their family?

1.15. Chapter Conclusion

This chapter outlined the quantitative and qualitative research literature on how veterans and their partners are affected by living with combat-related trauma, highlighting significant gaps in terms of what we know about the experiences of families of UK veterans with PTSD/trauma. This chapter therefore concluded with a rationale for the present study and the aims of the research, which attempted to address some of this gap in the research.

2. Methodology

2.1. Chapter Summary

This chapter outlines the epistemological underpinnings of the research, in addition to describing and explaining the procedures that took place in the recruitment, data collection, and data analysis phases of the research. This section also discusses ethical considerations and plans for disseminating the study's findings.

2.2. Epistemology and Ontology

A fundamental initial step when undertaking qualitative research involves considering the theoretical and philosophical positions from which the research will be undertaken, which will inform each stage of the research process – including the method of data collection and analysis, and how the results or *knowledge* gained from the inquiry will be understood (Guba & Lincoln, 1994; Madill, Jordan, & Shirley, 2000; Carter & Little, 2007). The researcher therefore needs to consider their standpoint on both the nature of reality – their *ontological* position, and their view on the nature of knowledge and what it is possible to know - their *epistemological* position (Ritchie & Lewis, 2003; Braun & Clarke, 2013). This section briefly summarises the various positions that researchers may align themselves with, and outlines the considerations made by the researcher when deciding upon the philosophical standpoint for the purpose of the current research.

2.2.1. Ontological assumptions. The ontological position adopted by the researcher will depend on their view about the relationship between people and the world in which we live. This can be conceptualised on a continuum with *realism* and *relativism* at opposite ends of the dimension. Those who adopt a realist view assert that there is an external reality separate to the existence of humankind, which is independent to the social processes and constructions of people (Boyd, 1983; Braun & Clarke, 2013). In this sense, they believe that

there is one true reality, which is able to be accessed by researchers if they apply the ‘right’ methods, which tend to be objective and quantitative in design. However, critics of this perspective argue that it is impossible to completely remove the influence of the researcher from the research process, such as their choices, interpretations and biases, even when the methods applied are the most experimental and rigorously objective. Indeed, they argue that the very essence of research is that it is a human act which is entwined in social processes. Therefore, eliminating the influence of these from the study of an ‘objective reality’ is, some would argue, impossible to achieve. This has led to the more moderate *critical realist* position, which although assumes that there is a true reality, holds the view that we cannot fully access it (Danermark, Ekström, Jakobsen, & Karlsson, 2002). As above, this approach notes that because people are socially-located, sense-making beings, we can only access reality to the extent that it is filtered through our subjective existence.

Alternatively, researchers who adopt a *relativist* position assume there are multiple, co-existing realities, which are predominantly social. This view states that there is no one true reality, but individuals construct their realities through their interactions with other people, making meaning through the socially available narratives associated with that place and time (Burr, 2003; Grbich, 2012). In a sense, proposers of this view state that there is no reality separate from the social world, and we can never access a truth which lies apart from our construction of it. Central to this position is that our understanding of a particular phenomenon is strongly influenced by the time and place in which we are experiencing it, which means that knowledge and the boundaries of what we can know is linked to the context in which it is generated (Gergen, 1985; Burr, 2003; Braun & Clarke, 2013). An example of the importance of considering the impact of context on the construction of meaning, is the way that good child-rearing practices have been understood differently over time. Whilst in Victorian times, child-care and parenting were constructed as needing to be strict and

disciplinarian in a context where children were ‘seen and not heard’, this is in stark contrast to the current dominant construction of preferred child-rearing practices, in which children’s rights are prioritised and it is seen as appropriate to encourage them to express their opinions. Indeed, the constructionist approach encourages us to challenge taken-for-granted assumptions about the social world (Gergen, 1985).

2.2.2. Epistemological assumptions. Linked to ontological positioning is deciding on a philosophical stance on epistemology. This represents the researcher’s view on what legitimate knowledge is and how we can know it. A key question is whether knowledge is conceptualised as something that can be *accessed* through the research (i.e. consistent with a realist stance of reality) or whether it is *created* (i.e. as would be the case from a relativist stance), such as via a co-constructive process between researcher and interviewee (Braun & Clarke, 2013).

Positivism suggests that it is possible for researchers to gain access to a reality that is fully knowable, meaning that the knowledge we gain exactly represents ‘the real world’. Proponents of this approach dictate that this is achievable if the methods employed are rigorous, objective and designed to eliminate any bias from the process. This approach is linked to the paradigm of empiricism that dominates in science, although there is increasing recognition that this is difficult to achieve within the human sciences and studies of social processes (Madill et al., 2000). There has been a shift therefore towards *post-positivism*, in which it is assumed that it is still possible to know a true reality but that it this is likely to be influenced by the social context in which the research is undertaken. Their methods in the quest for knowledge, however, would still seek to minimise bias and subjectivity as it is understood in the empiricist paradigm.

Constructionism, on the other hand, is closely linked to the relativist ontological stance of reality. Knowledge is conceptualised as being a process whereby individuals construct their realities through their interactions with other people, in the particular socio-politico-cultural setting in which they inhabit (Burr, 2003; Braun & Clarke, 2013). This therefore means that the construction – or creation – of knowledge will vary and adapt as the context changes, and that it can be strongly influenced by shifts in the social landscape (Braun & Clarke, 2013).

2.3. Epistemological and Ontological Assumptions of the Current Study

The majority of previous research into partners' experiences of living with veterans with combat-related trauma/PTSD appears to have been undertaken from a realist, positivist or critical realist stance. Indeed, as mentioned in the introduction (p.54), the bulk of research into this area has been quantitative in nature, employing standardised measures and other questionnaires to assess the level of symptomology experienced by partners (e.g. Dirkzwager et al., 2005; Frančišković et al., 2007; Klarić et al., 2012). Although it is not stated explicitly, research designs of this nature tend to assume that they are measuring the 'truth' about some aspect of the partners' realities, which directly corresponds to what they are experiencing. Consistent with their epistemological foundations, these studies discuss their methodological limitations in terms of their validity and reliability, and the implications for generalising findings to the wider population – which again hints at some knowable truth which could apply validly to other people who could be said to share a similar reality.

In regards to the existing qualitative research carried out into this area, those studies which stated their epistemological position have all been undertaken from a phenomenological stance (Frederikson et al., 1996; Lyons, 2001; Dekel et al., 2005a). Their research, therefore, was interested in the lived experiences and perspective of their

participants, used a small sample size (ten or less interviewees), and aimed to analyse the data by remaining as close as possible to the individual interviewees' accounts. This approach acknowledges that the context and the subjectivity of the researcher influences the processes of data collection and analysis, and that the person's reality cannot be accessed in isolation from their interpretation of it. However it places less emphasis on the process of socially-created meaning and the influence of dominant narratives on this process.

In summary, the existing body of research contributes to our understanding of the experiences of partners of traumatised veterans, particularly in terms of answering questions about their lived experience and perspectives. In this researcher's view, there is a gap in the literature and a theoretical argument for researching this area from a constructionist epistemology, given the complex and ever-changing way in which combat-related trauma is understood by society. Additionally, the current existence of multiple and conflicting narratives around PTSD, veterans, the military and warfare are likely to play some part on the way in which veterans and their families construct their experience of living with trauma. This study therefore utilised a qualitative methodology, adopting a social constructionist epistemology and relativist ontological position, as the research questions centred on understanding how participants constructed their experience of living with trauma/PTSD, within the current UK society. This approach also allowed for consideration of the researcher's role in the co-construction of these accounts.

2.4. Position Statement on the Use of Psychiatric Diagnostic Labels

Linked to the social constructionist approach to understanding the world is a tendency to adopt a critical lens in regard to psychiatric labels, such as Post-Traumatic Stress Disorder. This viewpoint regards diagnostic labels as being, by their very nature, social inventions which are influenced by the context and environment in which they are employed (Young,

1995). Psychiatric labelling (and the often associated prescription of psychotropic medication) has also been critiqued by proponents of the anti-psychiatry movement, for being an abuse of professional power which oppresses an already marginalised group in society. Recently the British Psychological Society's Division of Clinical Psychology (DCP) published a long-awaited position statement on psychiatric diagnosis, arguing that the "conceptual and scientific limitations" (p.1) of diagnostic classification manuals (such as the *DSM-IV-TR* (APA, 2000)) lead there to be an unjustified over-emphasis on biological causes of emotional difficulties or mental 'disorders', and underplay of possible psychosocial factors. The implications of this, they argue, is that the complexity needed for us to have a fuller understanding of the causes, maintenance and treatment of emotional distress is lost (Division of Clinical Psychology, 2013).

For these reasons, the present study adopted a similarly critical approach to the use of the label *PTSD*. This meant that this term was not solely used in its recruitment adverts and information sheets (the more general term *trauma* was also used), and participants' veteran partners did not have to have been formally diagnosed with the condition. Partners were able to take part if their perception was that their veteran partner had been traumatised in some way by their combat experience. However, arguably even adopting the term *combat-related trauma* or *trauma* is essentially itself applying a psychological label to someone's experiences. Nevertheless, it was hoped that this broader definition – in addition to remaining consistent with the critical approach to labelling – would also allow people to take part whose partners either did not wish to seek or adopt the PTSD label, whose experience did not fit the diagnostic criteria, or those who were at different stages of realising there was a problem.

2.5. Setting

Participants were recruited via the organisation Combat Stress, a charity that works with veterans and reservists from the Armed Forces who experience mental health difficulties. They provide treatment for psychological problems, information and support for veterans and their families. The organisation has three residential centres in the UK, where veterans can access intensive treatment programmes, and they also offer community outreach support and a 24 hour helpline. Combat Stress also holds regular support and information groups, which carers/family members are welcome to attend.

Participants were also recruited via Ripple Pond, a peer-led charity who provide support groups for adult family members of injured servicemen and women, and also support affected individuals to set up their own group in their local area.

2.6. Procedure

2.6.1. Recruitment procedure. Recruitment focused on London, the East and South East of England regions due to cost and time constrictions. Participants were recruited in a number of ways: a) the researcher attended two Combat Stress support groups in different regions to inform partners about the study; b) clinical staff from Combat Stress discussed the research with partners, and with their consent, passed on their contact details to the researcher; c) Ripple Pond were provided with an email version of the recruitment advert, which was emailed to members who lived in the geographical areas covered by the research; d) information about the study was also posted on Ripple Pond's website, Facebook and Twitter pages. Emails were distributed via Ripple Pond on three occasions, and Combat Stress were similarly provided with regular reminders, to increase recruitment rates.

The recruitment advert (Appendix B) was distributed to interested parties, either by the researcher or the organisations assisting with recruitment.

2.6.2. Attempts to overcome barriers to recruitment. When initial attempts at recruitment proved slow, in addition to following up with Ripple Pond and Combat Stress, further organisations were also contacted. This included the Warrior Programme and SSAFA (formally known as Soldiers, Sailors, Airmen and Families Association), whose websites indicated that work with families was within their remit. However, these organisations did not respond to email contact, and following a face-to-face discussion with SSAFA, they indicated that their work took more of a practical form and was not often associated with PTSD. They therefore advised that they would be an inappropriate route of recruitment. The decision was thus taken to revise one of the inclusion criteria (about having to have been in a relationship with the veteran whilst they were deployed and before the point of traumatisation) to allow more interested individuals to take part in the research (see 2.7.2.3 below for further information). This was felt to be a strategy that would increase recruitment rate as a significant number of individuals had made contact during the initial stages of recruitment, but had to be excluded due to this particular criterion.

2.6.3. Research procedure. Once an individual expressed interest in participating in the study, they were contacted either by telephone or email to provide them with the participant information sheet and consent form, discuss the study and answer questions, and to ensure that they met the inclusion criteria before continuing. Once they had had a chance to review the study information, they were contacted again to ask whether they would like to take part, and if so a date, method of interview (e.g. face to face or telephone) and location was arranged. Participants were given the choice about whether the interview was held at their home or elsewhere. Informed consent procedures were repeated at the beginning of the interview meeting, whereby the points on the consent form were discussed and participants were asked to sign to form if they were still happy to proceed. Interviewees were offered a

£10 high street voucher for participating in the study and were asked whether they would like to receive a summary of the research findings once it was completed.

2.7. Sample

2.7.1. Sample size. The aim was to recruit between 12 and 20 partners of veterans to participate in the study. This number represented the sample size recommended by Braun and Clarke (2013) for a medium-sized project using thematic analysis. This sample size, according to Braun and Clarke, allows for adequate identification of patterns across the data set.

2.7.2. Inclusion/exclusion criteria. The sample of participants were recruited with a number of inclusion and exclusion criteria in mind (see Table 2). The justification for these criteria are outlined below.

2.7.2.1. Non-discriminatory definition of ‘partner’. It was deemed important to not just include “the usual suspects” who make up the majority of research participants, that is, individuals who represent the dominant group in society – typically white, middle-class, educated, able-bodied, and heterosexual (Braun & Clarke, 2013, p. 58). The bulk of research into the experiences of couple relationships where one member is a veteran, typically involve female partners of male service personnel, meaning that homosexual relationships or those where the female in a relationship is the veteran are especially under-researched. Therefore, recruitment materials made it clear that male civilian partners and those in non-heterosexual relationships were able to take part.

2.7.2.2. Relationship length. It was specified that the couple needed to have been in a relationship for at least two years. This was because it increased the chance they will have transitioned from the initial *passionate love* stage of their relationship (Hatfield & Rapson, 1993), into a stage where patterns of relating and communicating had perhaps become more

established. The longevity of their relationships also meant that they were more able to reflect on changes and differences since the introduction of trauma into their lives and family systems, and/or since the early stages of their relationships. Even for those couples who started their relationship post-trauma, it may be that the true extent of the difficulties did not emerge until later in their relationships, meaning that participants in this situation may be able to reflect on changes in their relationship dynamic and expectations over time.

2.7.2.3. *Together when combat-related trauma occurred? Revision to inclusion and exclusion criteria.* An additional inclusion criterion originally stated that the couples must have been in a relationship *before* the point at which the veteran was recognised as being traumatised by their combat experiences. However, once the process of recruitment had started, it became clear that this was too restrictive a criterion for enough partners to be recruited within the available timeframe, therefore it was omitted.

The rationale for the original criterion was informed by research on the initiation of romantic relationships which puts attachment style at the centre of this process. Although there is debate about whether people are attracted to potential romantic partners who either have a similar attachment style to them or a complementary attachment style, research suggests that the internal working models that individuals hold about self and other can have an important influence on relationship choice (Holmes & Johnson, 2009). Likewise, in addition to attachment style, individuals may differ in their use of attachment relationships to fulfil a sense of safety and security (Holmes & Johnson, 2009). For example, it could be argued that for individuals who knowingly enter into a relationship where one member is perceived as traumatised and is perhaps struggling to show intimacy and affection, the partner may nevertheless be attracted to this relationship unconsciously as it fulfils their attachment goal to maintain their sense of security through caring or ‘rescuing’ another. Alternatively, the relationship could be maintained by the relational difficulties associated with the trauma

as it confirms the partner's longstanding view of themselves (say as unlovable), which provides security through its predictability (Holmes & Johnson, 2009).

Initially, it was decided to only include couples where the trauma occurred since they entered a relationship, hence increasing the possibility of hearing how the participants constructed any change in their relationships post-trauma. However, it was deemed acceptable to omit this criterion to boost recruitment numbers as it was re-evaluated as not being necessary to answer the study's research questions. Nevertheless, the concepts of partner choice and reasons for entering a relationship are still relevant, in addition to any differences in findings between participants who knew their veteran partner before, or only after, traumatisation.

2.7.2.4. Tours and conflicts. There were no limits on which conflict/s the veteran was involved in and how long ago it was since they were discharged from the Forces. Indeed, the bulk of existing research has focused on Vietnam War veterans (e.g. Outram et al., 2009; O'Toole, Outram, Catts, & Pierse, 2010; Renshaw, Campbell, Meis, & Erbes, 2014), and more recently veterans of Iraq and Afghanistan (e.g. Goff et al., 2009; Fear et al., 2010; de Burgh et al., 2011). However, in the UK in 2011, Combat Stress reported that the tour most commonly served in by veterans on their caseload was the Northern Ireland conflict (Busuttil, 2010); a group which has received less research attention in terms of the effects on both veterans and their partners. It was therefore decided to keep this criterion undefined and open to maximise variation in geographical location and the years the veterans were involved in active conflict. There were also no limits on whether or not the veteran or their partner were receiving, or had received, treatment for mental health difficulties.

Table 2:

Inclusion and exclusion criteria involved in selecting research participants

<u>Inclusion criteria</u>	<u>Additional exclusion criteria</u>
Male or female partners (aged 18 years or above) who were in a relationship with a veteran (both same-sex and opposite-sex relationships applied)	Partners who were separated from the veteran and no longer in a relationship
The individual was <u>currently</u> in a relationship with the veteran (either married, civil partnership, common law partner, or cohabiting)	Partners who had been widowed
The couple had been in a relationship for at least two years	Partners who were also current or ex members of the Armed Forces
The veteran partner was involved in active service for the British Armed Forces for at least one day (including Reserves called upon for duty)	
The veteran partner was no longer a member of the Armed Forces or the Reserve Forces	
They perceived that their veteran partner was experiencing a problematic reaction to combat-related trauma, which may or may not have been formally diagnosed as PTSD	
<i>NB: <u>The following inclusion criterion was omitted part way through the recruitment process, due to slow recruitment: They were in a relationship whilst their partner was deployed and before the point that they began to show symptoms of traumatisation</u></i>	

2.8. Materials

An interview topic guide was developed and used to guide the inquiry (Appendix C) in line with the study's research questions. This consisted of bullet points of the areas that ideally would be covered during the interview, but did not specify exact questions or an order in which they would be asked. This was to allow participants to tell their story in a free-flowing way and to talk about what they felt was important to them, as long as it was within the realm of the research questions. The interview guide was developed via consultation with one of the research supervisors of this thesis (SMP), through reaching consensus on the key

areas that would need to be covered for the research questions to be addressed. Prompt questions were included to facilitate conversation, particularly to encourage participants to give specific examples of the situations or difficulties they were describing. An item was included to prompt about any positive elements of living with combat-related trauma to caution against the interviewer overly focusing on negative aspects of their experience. The beginning introductory blurb, and the specific wording of the questions and prompts, were not following directly as written but were used flexibly. For example, the interviewer would use the participants' own language to clarify what they had said and to ask follow up questions.

Interviews were expected to last for between one and one and a half hours. Participants were provided with an information sheet and consent form (Appendix D and E), and a list of contacts for support services for veterans and their families (Appendix F). Before the interview, participants were asked to complete a short questionnaire focusing on demographic information about them, some details about their veteran partner (whether they have been diagnosed with a mental health difficulty, the nature of their deployment, etc.) and their relationship (e.g. whether they are married, how long they have been together, etc.) (see Appendix G). A digital recorder was used to audio-record the interviews.

2.9. Analysis

The interviews were transcribed verbatim and anonymised (names, locations and any other details that could compromise confidentiality) before analysis (see Appendix H for an excerpt of an interview transcript). The transcription notation used was adapted from Braun and Clarke's (2013) recommendation, a copy of which can be found in Appendix I. The qualitative data analysis software package MAXQDA (Version 11) (VERBI Software – Consult – Sozialforschung GmbH, 2012) was used as a way to organise and support the

analysis process (see Appendix J for an excerpt of the MAXQDA coding frame developed during the analysis process).

2.9.1. Selecting an analytical approach. A number of different approaches to analysing qualitative data are available, and selection of an appropriate method should involve consideration of what would most adequately be able to answer the research questions of a particular investigation. With qualitative methodologies, the chosen approach must be consistent with the epistemological and ontological assumptions of the study, and it is the case that some analytic approaches contain these assumptions already within them (i.e. these are a non-modifiable element of the particular method and approach to analysing data). A number of options were therefore reviewed for the purpose of the present study, as outlined below.

2.9.1.1. Interpretative Phenomenological Analysis (IPA). IPA (Smith, 1996) is an approach which is interested in people's perspectives and experiences, and therefore can be used to answer research questions that aim to access data of this nature. It is a 'ready-made' methodology in the sense that it has phenomenology (that is, the study of experience) as its core assumption about the world, and it has an idiographic focus on the individual experiences of each research participant, although does involve some thematic comparison across data collected from all participants (Braun & Clarke, 2013). It is not an appropriate method for studies where the focus is on how knowledge and reality are constructed, and therefore was not selected for the purpose of the current research.

2.9.1.2. Grounded theory. Grounded theory was one of the original qualitative methodologies, originally pioneered by Glaser and Strauss (1967). Since then there have been numerous adaptations and modified versions of the original method, including those carried out from a range of epistemological positions (for example, Charmaz's Constructivist

Grounded Theory (2006)). One of the distinctive features of grounded theory includes theoretical sampling, whereby the researcher recruits, interviews and analyses the data from one participant at a time, looking at what characteristics may be necessary to fully answer the research question (e.g. finding someone of a different age group) before recruiting the next individual. This continues until the point of ‘data saturation’ when the researcher decides that additional interviews would not add any further depth to the emerging theory. The end aim therefore is to devise a theory that adequately explains the data collected from the sample. Traditional grounded theory also states that researchers should not base their study on pre-existing literature or theories, but to allow the theory to develop from the participants’ interviews in a bottom-up, data-driven way. A critique of this is that modern ethics procedures require researchers to have engaged with the existing research evidence before commencing their projects, meaning this is often unfeasible in practice (Braun & Clarke, 2013). Although grounded theory may have been appropriate for the current study, it does not have the epistemological flexibility of some other approaches (i.e. thematic analysis). Additionally, some elements of the methodology (e.g. theoretical sampling) are often omitted in small or medium-scale research projects for practical reasons (Braun & Clarke, 2013), therefore meaning they are not truly a grounded theory project. Therefore, to avoid these limitations and for feasibility reasons, this method was not selected for the present research.

2.9.1.3. Discourse analysis. Discourse analysis is an umbrella term for a wide range of approaches that regard language and its usage as being central to human experience and knowledge, such that meaning is constructed by language. These approaches have in common an interest in how language is used and structured, which in the analysis of research data, often includes a detailed examination of both the minutiae of the structure of speech as well as how it relates to wider societal discourses (Braun & Clarke, 2013). Although the present study’s research questions were concerned with how societal influences impacted the

participants' constructed experiences, the emphasis was not specifically focused on the role of language in this process. For this reason, discourse analysis was not selected for the purpose of the present research.

2.9.2. Social constructionist thematic analysis. The method of analysis selected for the purpose of the present study was thematic analysis, which for reasons outlined above, was conducted from a social constructionist/relativist standpoint. Thematic analysis is an atheoretical approach, so therefore must be combined with the epistemological standpoint from which the research is being undertaken. A number of researchers have successfully applied this method of analysis within a constructionist framework (e.g. Clarke & Kitzinger, 2004; Braun, 2008). Thematic analysis was chosen for its epistemological flexibility, and because it is appropriate for use in research which focuses on how social topics are constructed (Braun & Clarke, 2006; Braun & Clarke, 2013).

Braun and Clark specify that thematic analysis can be carried out in different ways depending on the researcher's aims for the purpose of the analysis (Braun & Clarke, 2006; Braun & Clarke, 2013). Specifically, this involves consideration of the following dimensions: (1) whether the approach is inductive or theoretical – that is, whether it is a 'bottom-up' approach or whether analysis is informed by pre-existing theories and ideas; (2) whether the analysis is descriptive or analytical/interpretative – namely, whether it seeks to just describe the 'what' or whether the analysis is conducted on a deeper analysis to consider the 'why'; (3) and whether the researcher adopts an essentialist (realist) or constructionist approach – which, as mentioned above (p.58), will determine whether the analysis is presumed to be accessing participants' 'reality' or whether it represents what is created via the research process. The latter two points would dictate whether the analysis focuses on themes that represent purely the semantic content of the data, or whether latent themes are also included.

For the current research, decision-making along these dimensions was driven strongly by the study's epistemological and ontological positioning. Thus the approach to analysis was, at least predominantly, theoretically-driven in terms of it being informed by systemic theories of trauma and relational behaviour in general. This aimed to provide a deep interpretative analysis of the data, including latent aspects such as underlying assumptions and the meanings being constructed. One focus of the aims of the research was to explore the impact of social narratives associated with combat-related trauma and related concepts, within the particular socio-political landscape of our time. Therefore, it was appropriate to adopt a critical approach to analysis to allow these wider contextual factors to be considered in the interpretation of themes. In this sense, the resulting analysis from a constructionist thematic analysis can look very similar to a thematic discourse analysis, however a key difference (and an identified short-coming of thematic analysis) is that thematic analysis is not an appropriate method for the detailed study of language practice and structure (Braun & Clarke, 2013).

2.9.3. Six phases of thematic analysis. The specific structured method of thematic analysis utilised for the analysis was of that outlined by Braun and Clark (2006; Braun & Clarke, 2012, 2013). This approach indicates six phases which were followed during the analysis stage; these are discussed briefly in turn below.

2.9.3.1. Phase 1: Familiarisation with the data. This involved listening to the audio-recordings of the interviews and reading over the transcripts to begin to note key themes and ideas, which appeared at this initial stage to answer some element of the research questions. As recommended by Braun and Clarke (2006), this stage was facilitated by questioning what underlying assumptions or world view was being constructed in the accounts. These initial ideas were recorded in the researcher's reflective diary and were used to inform the more systematic coding of the data.

2.9.3.2. Phase 2: Generation of initial codes. Each transcript was coded systematically, using a combination of both semantic (i.e. staying close to the more obvious content of the text) and latent (i.e. underlying assumptions and interpretation of the semantic content) codes. As mentioned above (see 2.9.2), this analytical phase also made use of theoretical frameworks where these helped make sense of the data. Coding at this stage involved concise labelling of elements within the data, which were not fully synthesised and explained until later on in the analysis process.

2.9.3.3. Phase 3: Generating themes. At this stage, the coded data was analysed across the whole data set and themes were therefore constructed; that is identifying meaningful patterns that were relevant to answering the research questions. This phase involved restructuring some of the coding frame to either collapse or separate codes as the themes were reviewed. Thematic maps were drawn out on paper to ascertain the best representation of the data and to allow for the relationship and overlap between themes to be illustrated. This assisted in the process of identifying where overlap was needed to represent the complexity of the data, and other areas where it meant that two or more themes were too similar and needed to be refined.

2.9.3.4. Phase 4: Reviewing themes. This phase required the researcher to take a step back and review the themes, allowing for a process of quality control. Specifically this involved making sure that the themes still adequately represented the coded data extracts within them, or whether their evolution had taken them too far away from the (latent or semantic) content. Additionally, the themes were reviewed in relation to the interviews as a whole, in terms of whether they sufficiently told the story of the data. Themes were added, revised, or collapsed into a similar theme where necessary.

2.9.3.5. Phase 5: Defining and naming themes. Themes should be distinct but related, and the researcher should be able to describe the boundaries of each and any relationship to other themes (Braun & Clarke, 2012). To ensure that this was the case, and that they were relevant to the study's research questions, a brief description of each theme was written by the researcher. At this stage, data extracts were identified which exemplified the essence of each theme, which would be used in the analysis section to justify and illustrate the findings. It was ensured that all participants were represented in the chosen extracts, and for this to be as evenly spread as possible. A final task within this phase was to name each theme, in a way that captured the reader's attention and concisely depicted their essence.

2.9.3.6. Phase 6: Producing the report. Finally, the themes were written up in a coherent narrative which represented the story told within the data set.

2.10. Quality and Qualitative Research: Establishing Trustworthiness

As this study has not adopted the positivist notion that there is one 'true' reality, the related framework for assessing the quality of research was also rejected. Therefore, instead of evaluating the reliability and validity of the research (as is the case with positivist and typically quantitative approaches), the alternative approach cited by Lincoln and Guba (1985) was adopted. Although numerous criteria have been developed, Lincoln and Guba's remains the gold standard (Whittemore, Chase, & Mandle, 2001). They proposed that the concept of *trustworthiness* was more appropriate for evaluating qualitative research, whereby a study is trustworthy if *credibility*, *transferability*, *dependability* and *confirmability* are established.

Credibility refers to the extent to which the analysis reflected what the participants were saying and how representative it was of their 'truth'. Lincoln and Guba (1985) suggested a number of strategies to increase the credibility of qualitative research, some of

which were employed in the current study. Analyst triangulation was employed through another researcher coding a transcript, and this being compared with the principal researcher's interpretation. In the spirit of the constructionist epistemology underlying this research, each individual's interpretation was not deemed 'right' or 'wrong' but this process allowed for occasions to be identified where the analysis did not appear to represent an element of the (semantic or latent) content of the data. Research supervisors were also involved in reviewing the themes (via discussion of the MAXQDA coding frame), to provide a further element of triangulation. The analysis also utilised the technique of *negative case analysis* whereby efforts were taken to identify extracts that challenged a particular idea or theme (Mays & Pope, 2000); this helped the researcher to remain open to considering data from different angles.

Transferability refers to the ability to confidently decide whether one study's findings are relevant to another population (Lincoln & Guba, 1985). For this to be the case, the researcher needs to explicitly and thoroughly describe the context in which the original research was carried out. The current study worked to fulfil this criteria by describing the research methodology in detail, describing the demographic details of the participants and their partners, in addition to the nature of their relationships and on which tours their partners had served. There was also discussion of the socio-political context in which the research was carried out, for example in a climate of withdrawing troops from Afghanistan, high levels of redundancies, and general financial austerity measures. It was hoped that this detail would be sufficient for those reviewing the research to decide on the transferability to their settings and purposes.

Dependability refers to the extent that the research was consistent and whether there was enough transparency and detail about the methods so that it could be carried out by another researcher. To this end, memo-taking and use of the research diary was undertaken to

keep track of decision-making throughout the process (Johnson & Waterfield, 2004). Major changes (e.g. changes to inclusion and exclusion criteria) were reported, as were the number of participants who chose not to participate in the study and the reasons why. The use of qualitative data analysis software allowed for codes and themes to be stored efficiently and transparently.

Finally, confirmability relates to the research process and analysis being relatively ‘value-free’ and not unduly influenced by the researcher’s biases. However, research from a constructionist perspective posits that it is impossible to remove the influence of the researcher from the process, and in fact, this adds to the richness of the findings rather than detracts from it. Indeed, this epistemological position suggests that ‘knowledge’ and ‘reality’ are constructed in the interaction between interviewer and respondent (Burr, 2003). However, it is essential that the researcher maintains a reflexive stance throughout and acknowledges the role that their previous experiences, background, preferences and assumptions has on the participant and the co-construction of knowledge (Mays & Pope, 2000). This was facilitated in the current study by the use of reflective diary, and is discussed in detail towards the end of this thesis. An extract from this diary is displayed in Appendix K.

2.11. Ethical Issues

2.11.1. Ethical approval. Ethical approval was granted from the University of Essex Science and Health Faculty Ethics Committee, as were amendments to ethical approval that were submitted at a later date (i.e. in relation to removing an inclusion criterion). A research request form was also submitted to Combat Stress, which was reviewed and approved by their Research and Ethics Committee. Documents confirming ethical approval and amendments can be found in Appendix L.

2.11.2. Managing the potential for distress. Although interviewees were not asked about the traumatic events that their partners experienced, or to specifically talk about distressing situations that have occurred within their relationships, it was deemed possible that an individual may become upset during the course of the interview. Interviewees were therefore reminded that they could take a break whenever they wished, did not have to continue with the interview, or share anything that was too difficult for them to talk about.

It might also have been the case that some of the partners were experiencing a high level of distress, and potentially significant mental health difficulties, as a result of their current situation. In addition to being given a list of support services, if relevant, the participants were also offered a pre-prepared letter to give to their GP (and/or their contact at Combat Stress, if appropriate) (Appendix M). This letter explained that the individual participated in this research, that there were indications that they are experiencing a problematic level of psychological distress, with a recommendation that the GP discuss this with them.

To prepare for the possibility that there may be more acute levels of distress, a crisis management strategy was outlined, which participants were informed of in the study's information sheet. This involved gaining consent to contact the GP (or emergency services) directly, or to break confidentiality without consent if there was significant risk to the individual's safety. However, although there was always the potential for distress, similar studies have reported that interviewees found it to be cathartic and empowering to talk about their experiences of living with trauma, and took satisfaction in that sharing their story could help others in a similar situation (Frederikson et al., 1996).

2.11.3. Safeguarding. An additional consideration was safeguarding – of both the interviewee, the veteran, and any children in the family. The consent form, and verbal

consent procedures, ensured that interviewees understood that the researcher's duty of care meant that confidentiality may need to be broken and information passed to relevant organisations (e.g. police, social care, GP) if there was evidence that they, their partner, or their children, were at significant risk of harm. Participants were informed that attempts would be made to gain their consent before passing on information, but in these situations professional duty of care would take priority over maintaining confidentiality, as recommended in safeguarding guidance for researchers (Furey et al., 2010; Shaw, Brady, & Davey, 2011).

2.11.4. Right to withdraw. The process of gaining informed consent involved making participants aware that they had the right to withdraw their involvement at any point in the study up until the point at which the thesis or other publication had been written up. This included the ability to request that their data be removed after they had completed the interview. They also were asked specifically if they gave their consent for their interview to be audio-recorded and transcribed.

2.11.5. Personal safety. To ensure the researcher's safety when conducting interviews in people's homes, the lone-working service Guardian24 was used. This allowed the researcher to register her location on arrival and when she had safely left the interviewee's home. This service would make contact with the researcher if she had not checked in at the agreed time, and if there was no response, would have arranged emergency assistance.

2.11.6. Data protection and confidentiality. As mentioned above (see 2.9), data was anonymised at the point of transcription and hand-written notes (e.g. memos, reflective diary) were also anonymised. Audio files and transcription files were password protected and saved on a password protected laptop, in line with the Data Protection Act 1998 (Great Britain

Parliament, 1998). The audio files will be permanently deleted following the successful completion of the thesis and viva, in line with University procedures.

2.12. Dissemination

Participants indicated on the consent form whether or not they wished to receive a summary of the research findings. Ripple Pond and Combat Stress will be provided with the summary and will be offered for the researcher to present the research to these teams. At least one paper will be submitted for publication in an academic journal and a proposal will be submitted for presentation at least one relevant conference. Interviewees will also be asked about ways that they feel would be appropriate for the findings to be disseminated to them and other partners in a similar situation. This may involve linking in with peer support groups and social media, and potentially mainstream media, as appropriate.

2.13. Chapter Conclusion

This chapter outlined the design and procedures of the research study, including steps taken in an attempt to compensate for initial difficulties in recruitment. This section also discussed the rationale for the methodological choices which were made, ethical considerations and plans for disseminating the study's findings.

3. Results

3.1. Chapter Summary

This chapter outlines the demographic information of the individuals who participated in the study, and those who dropped out or declined to participate. It also provides an in-depth exploration of the five themes that were constructed during the interview and analysis process, supported by extracts from the participants' accounts.

3.2. Demographics - Participants

Fifteen partners of veterans were interviewed, all of whom were women in heterosexual relationships. The demographic information collected from the women about themselves and about their relationship with their veteran partners is displayed in Table 3. An additional 10 women had also expressed interest in participating but were unable to for a variety of reasons. This included not meeting the inclusion criteria due to: being divorced from their partner ($n = 1$); living outside of the recruitment area ($n = 3$); or being related to the veteran in another way rather than being their partner ($n = 1$). Two other participants decided not to participate due to a worsening in their partners' mental health difficulties or other life crises, and three did not respond to follow up correspondence.

The majority of women who continued on to participate were recruited from Ripple Pond ($n = 10$) and the remainder from Combat Stress ($n = 5$). Two participants were recruited and interviewed before the inclusion criterion was omitted about needing to have been in a relationship with their veteran partner whilst they were deployed and before the point of traumatisation. The remainder were interviewed after this point, although in the end, 60% of participants would have met this original criterion as they had been in a relationship whilst their veteran partner was deployed. Most of them chose to be interviewed in their own homes, however one participant opted to talk over the telephone, and four other interviews

were carried out at various locations within the community (e.g. pub, café, church). The length of the interviews ranged from 52 minutes to 112 minutes, and were 75 minutes on average.

Table 3 <i>Demographic Information about Partners and Veterans</i>		
Demographics	Partners (<i>N</i> = 15)	Veterans (<i>N</i> = 15)
Age		
Mean age (years)	42 (<i>SD</i> = 11.7)	43 (<i>SD</i> = 12.8)
Age range (years)	26 – 69	29 – 69
Ethnicity		
White British	13 (86.6%)	13 (86.6%)
British Asian	1 (6.7%)	0 (0%)
Mixed White	0 (0%)	1 (6.7%)
British/Asian		
Mixed White/Black	1 (6.7%)	0 (0%)
Other (Fijian)		
Black Other (Fijian)	0 (0%)	1 (6.7%)
No. Children (\leq 18 years)*		
0	4 (26.7% of couples)	
1	3 (20% of couples)	
2	2 (13.3% of couples)	
3	3 (20% of couples)	
Adult children ($>$ 18 years)	4 (26.7% of couples)	
Relationship status		
Married	12 (80%)	
Not married	3 (20%)	
Living arrangements		
Cohabiting	13 (86.7%)	
Living separately	2 (13.3%)	
Relationship length		
Mean length (years)	17 (<i>SD</i> = 13.8)	
Range (years)	2 – 45	
In relationship when serving	9 (60% of couples)	
Relationship began post-service	6 (40% of couples)	

*Note. Total over 100% as some couples had children both younger and older than 18

3.3. Demographics - Veterans

The women were also asked to provide some details about the veterans' military careers and whether their partners had received any psychiatric diagnoses, which they answered to the best of their knowledge. These details are displayed in Table 4. All of the

men had received at least one diagnosis, with some having receiving more than one, according to the female partners. The two veterans who had not been diagnosed with PTSD had received a diagnosis of dissociative disorder or adjustment disorder. The large range in time since leaving the Forces and in time served was largely indicative of the ages of the veterans, which was also the case for the tours that they had participated in. Only one veteran was from a commissioned (officer) rank; the others were from non-commissioned ranks.

3.4. Variation within the sample: complexity and chronicity of trauma/PTSD

Analysis of the demographic details collected in relation to the veterans, in addition to qualitative data from the interviews with the women, suggested that there was significant variation in the length of time the veterans (and therefore the women and families) had been living with trauma/PTSD, and also the complexity of the condition. Specifically, the length of time since discharge from service ranged from one month to 39 years, meaning that some families had been living with difficulties relating to combat-related trauma for decades versus around one year. In turn, this had an impact on which stage each particular couple were at on their treatment journey, and level of optimism about how likely it was that a course of therapeutic input was going to have a beneficial effect. However, chronicity did not always mean that the longest suffering veterans were necessarily the most complex. For example, the veteran who was one of the most recently discharged was the individual diagnosed with dissociative disorder and who had received a significant amount of psychiatric inpatient treatment. Nevertheless, these variations within the sample were kept in mind during the analysis of the data and in the development of the themes outlined below.

Table 4
Descriptive Information Regarding Veterans' Military Service and Psychiatric Diagnoses

Demographics	Veterans (N = 15)
Most recent military rank	
Private (Army)	5 (33.2%)
Private (Royal Marines)	1 (6.7%)
Senior Aircraftman (RAF)	1 (6.7%)
Lance Corporal (Army)	2 (13.3%)
Corporal (Army)	3 (20%)
Leading Hand (Navy)	1 (6.7%)
Sergeant (Army)	1 (6.7%)
Lieutenant Colonel (Army)	1 (6.7%)
Length of service	
Mean length of service (years)	10 (<i>SD</i> = 6.2)
Range (years)	3 – 22
Time since leaving Forces	
Range	1 month – 39 years
0 – 5 years	8 (53.3%)
10 – 20 years	2 (13.3%)
>20 years	5 (33.4%)
Tours (location)*	
Afghanistan	7 (46.7%)
Bosnia	3 (20%)
Falklands	1 (6.6%)
Gulf	2 (13.3%)
Iraq	2 (13.3%)
Kosovo	3 (20%)
Northern Ireland	5 (33.3%)
Psychiatric diagnoses*	
PTSD	13 (86.7%)
Depression	5 (33.3%)
Alcohol abuse	2 (13.3%)
OCD	2 (13.3%)
Adjustment Disorder	1 (6.6%)
Dissociative Disorder	1 (6.6%)

*Note. Total over 100% as some veterans participated in multiple tours and had more than one diagnosis

3.5. Analysis

Five themes were constructed during the analysis, which are described in detail below, alongside selected excerpts from the participants' interviews. To aid the reader in

appreciating each individual's account, as well as the overall themes across interviews, pen portraits of the participants are outlined in Table 5 below.

Table 5

Pen Portraits of Participants

<u>Pseudonym</u>	<u>Description</u>
Veronica	was 42 years old and had been in a relationship with her husband for 19 years. They had two children. Her husband left the Armed Forces three years ago and they had been living with trauma-related difficulties since then, but were at the very start of their treatment journey.
Susie	was 51 years old and had been in a relationship with her husband for 34 years. They had four adult children. Her husband left the Armed Forces 14 years ago and had received some treatment for PTSD and depression, although his progress slowed once treatment was stopped. The couple were therefore at the beginning of a second attempt to gain help and Susie was seeking help for herself for the very first time.
Elsa	was 49 years old and had been in a relationship with her husband for 33 years. Her husband left the Armed Forces 12 years ago and had had mental health difficulties both during service and after discharge. He only received a diagnosis of PTSD recently, so the couple were embarking on a fairly new treatment journey after a number of failed attempts.
Angela	was 26 years old and had been in a relationship with her husband for 7 years. They had one child. Her husband left the Armed Forces five years ago and had received a diagnosis and pharmacological treatment around two years ago. Angela felt that there was still some way to go but their relationship and her husband's PTSD had improved since its worst point.
Miranda	was 69 years old and had been in a relationship with her husband for 45 years. They had one adult child. Her husband left the Armed Forces 39 years ago and struggled with symptoms of trauma almost immediately, although due to the decade in which he was discharged, this was not recognised as PTSD until much later. Miranda's husband had received many periods of both inpatient and outpatient treatment, and things had improved since their very worst point, but there was a sense of limited hope for the situation to be much better in the future.
Jane	was 62 years old and had been in a relationship with her husband for 33 years. They had three adult children. Her husband left the Armed Forces 30 years ago and had received a significant amount of treatment for PTSD, which Jane felt had had limited success. She reported little hope that the situation and their relationship would improve, and she was frustrated that she was unable to access appropriate support for herself.

Hilary	was 34 years old and had been in a relationship with her husband for three years. Her husband left the Armed Forces six months ago, and begun to experience symptoms of trauma post-discharge. They were at the beginning of their journey of seeking help, although were unsure of where this help would come from, but her husband had recently received a diagnosis of PTSD.
Elizabeth	was 42 years old and had been in a relationship with her husband for 24 years. They had three children. Her husband had formally been discharged from the Armed Forces one month ago, although had been on sick leave for one year. Her husband had received both inpatient and outpatient psychiatric treatment, and although there had been improvements in some areas, Elizabeth reported that the difficulties were still current.
Caitlin	was 31 years old and had been in a relationship with her husband for four years. Her husband had left the Armed Forces five years ago and had experienced difficulties shortly after discharge. He had not yet embarked on therapeutic intervention but had recently received a diagnosis of PTSD. Caitlin reported some optimism in the treatment and things improving in the future.
Georgia	was 51 years old and had been in a relationship with her husband for nine years. She had three children. Her husband had left the Armed Forces 30 years ago and had received numerous periods of therapeutic intervention for PTSD. Georgia reported being sceptical about the treatment and its ability to help thus far.
Karen	was 30 years old and had been in a relationship with her partner for two years. Her partner had been discharged from the Armed Forces 18 months ago but he had been on a period of sick leave before that. The couple were therefore at the very beginning of their treatment journey.
Thelma	was 37 years old and had been in a relationship with her husband for 11 years. They had three children. Her husband had formally left the Armed Forces six months ago but had been on a period of sick leave prior to that. Her husband had received periods of treatment within the military healthcare system and was just at the beginning of embarking on treatment within the civilian system. Although things had improved since crisis point, Thelma felt that the difficulties were very much still present.
Maria	was 38 years old and had been in a relationship with her husband for 17 years. They had two children. Her husband had left the Armed Forces 16 years ago but had been on a period of leave before that. Her husband had received multiple periods of treatment and different medications, and the couple were at the point where things had improved although some days were still difficult.

Sabrina	was 36 years old and had been in a relationship with her partner for 12 years. She had one child. Her partner had left the Armed Forces 24 years ago. Her partner had received periods of treatment and Sabrina noted that things had improved from crisis point, although it was still difficult.
Mary	was 38 and had been in a relationship with her partner for two years. Her partner had left the Armed Forces seven months ago, although had a period of sick leave before that point. Her partner had received some treatment which was still ongoing. Mary felt that things had improved significantly from their worst point, although felt there was still some way to go.

3.5.1. “Walking on eggshells”: Subduing own emotional and behavioural

responses. The women frequently constructed a process whereby they acted to avoid conflict or triggering of their partners’ trauma/PTSD symptoms by actively subduing their own responses. This included both emotional responses – for example, not displaying their own distress for fear of upsetting the veteran, and behavioural – such as walking away from an argument and ‘backing down’ rather than continuing with putting their own point across. This was particularly the case for dealing with anger, where the women felt it necessary to keep a balance on the level of emotional expression in the household and to try and have some control over the number of angry outbursts. For Jane, her self-monitoring was linked to a sense of inevitability over interactions ending in conflict, but Hilary constructed her husband’s anger as related to his vulnerability and it therefore being her job to make day to day life more comfortable for him. Although this process was common to the women, some of the variation in the way it was approached by Jane and Hilary may have been linked to how long they had lived with the symptoms of PTSD/trauma (33 years and three years respectively), and therefore how compassionate they were able to feel towards their partners.

It's very difficult because it's, what I would say is, walking on eggshells all the time, I have to watch what I'm saying all the time because I know what it'll be like if I say the wrong thing, it just all explodes, it erupts once again and I never know what to say, I never know what to do because I know what I do is wrong. (Jane, lines 191-194)

You always feel you're walking on eggshells because you don't want to trigger something or for him to get angry, or giving him more than one piece of information sends his brain into overload and he can't cope. (Hilary, lines 327-329)

In addition to trying not to provoke anger, the women also changed the way they reacted during arguments in an attempt to lessen the impact on themselves and their partners, usually minimising the extent to which they retaliated. For example, Elsa (lines 253-254) responded to being verbally insulted by her husband through using passive methods - "I have only defended myself by withdrawing, not by attacking him" - which was constructed as being less provocative and more submissive. However, some women also acknowledged the systemic, bidirectional impact of their behaviour in that these seemingly passive methods of dealing with conflict were sometimes perceived by their veteran partners as being just as powerful as 'fighting back', as the men were able to sense the women withdrawing and being less connected with the relationship. Others reflected that their feeling of being burnt out corresponded to times where they used ineffective methods of relating to the veteran, which then impacted their relationship, and in turn, the veteran's wellbeing:

and um like I said sometimes I have really cocked it up and that's made me feel really bad because I knew I wasn't helping. But I couldn't really control my emotions very well and I'd get really sarcastic, which as we know might seem hilarious at the time in how you put something but can be really quite destructive if it goes on for a while, especially when he wasn't doing very well because I knew he wasn't. It was only because I was worn out. (Mary, lines 702-706)

Unsurprisingly, subduing their own emotional needs eventually took its toll on the women, with a number of them mentioning having mental health issues or developing unhelpful patterns of behaviour that they constructed as being directly related to their

partners' difficulties. This meant that the very process of subduing their reactions was one way in which they felt they were personally impacted by living with combat-related trauma. This was the case both for women who were at the beginning of their journey of living with combat-related trauma and those who had experience of living with chronic PTSD/trauma, however the women who felt that their partners' situations had improved had also noticed some benefit to their own mental health. Within this theme, participants also referred to emotional avoidance and unavailability as being one element of their partners' trauma symptoms, and the impact of this was constructed as meaning that the women needed to find other ways to deal with their own emotional distress, as the veteran was unable to respond to family members' upset in the way that the women wanted. This included using alcohol, over-working in their career, taking psychotropic medication themselves, blocking out the veteran or building up defences. For Susie, this took the form of over-eating as a way to self-soothe and deal with her emotions, which in some ways appeared to mirror the self-destructiveness and withdrawal which her husband was also struggling with:

...avoiding conflict definitely. Now there are times when I- in my insides have wanted to scream and wanted to shout and I want to say hundreds of things, but again I don't. I don't. Um and I guess that's again when I end up eating. (Susie, lines 383-385)

Interestingly, there were other parallels between the nature of the veterans' trauma symptoms and some of the women's psychological experiences. For example, the process of self-monitoring and of carefully paying attention to the veterans' reactions and moods meant that the women often displayed significant hyper-vigilance themselves, a 'symptom' that underpins the diagnostic criteria for PTSD. However, their hyper-vigilance tended to be linked to current concerns about the veteran and other family members, rather than due to past traumatic events. It, however, was equally demanding on the women and they reported

feeling on edge, and felt – similarly to symptoms underlying the PTSD construct – that something bad was about to happen. For Miranda, the unpredictability and having to keep check on her husband's moods was the most difficult aspect of living with combat-related trauma whereas for Veronica, the constant process of being watchful of the interactions between family members took its toll:

That is the worst. It-it you don't know what you are going to wake up to everyday, you know depression and every- he has a study there and he'll sit in there for hours just playing FreeCell. Erm and it- it is um that impact, that is the worst. Er cos again he doesn't say oh I'm feeling down today, you've got to guess. (Miranda, lines 237-240)

Complete monitoring, you would- a Sunday dinner for instance was just the most awful experience because I would be watching what mood he was in, and then watch what my eldest daughter who's 21 might come out with which might antagonise the little one which then would antagonise Jack, so you are already watching what's going on with everybody's eye contact, body language, what mood they are in to make sure that that dinner situation was pleasant and didn't make Jack take something the wrong way or you know get him agitated so it's actually quite exhausting. (Veronica, lines 44-50)

The process of *walking on eggshells* had particular significance for the women whose relationships with their partner had previously involved physical violence, with it therefore being linked to maintaining their personal safety. This was the case for two of the participants, who constructed domestic violence in this situation as being a 'symptom' of PTSD and therefore something they could help the veteran deal with. This linked to the dilemma of working out whether the veteran was 'sick' or 'bad', which is discussed below as

having different implications for how the women chose to respond to their behaviour. Even though the abuse was historic and their relationships had improved and progressed to the point where they rationally no longer felt physically at risk, at times of heated emotion they noticed ‘flashbacks’ to that time and feared for their own safety:

You know, him jumping, he's throttled me, he's you know shoved me, gone to punch me, threatened me, squared up to me, offered to kill me, I mean right in your face and not allowing you to move. That's terrifying. And when he's bad, that comes straight back to me because I'm thinking gahh deep breaths, go over, make sure he's alright, don't touch him too heavily, make sure that you're safe um. That's the stuff that terrifies me. And yeah that really affects me, because after a few days where he's been bad I'm sitting there going okay it's going to be alright, as I say it's not- it's not a terror I can leave. (Maria, lines 736-742)

And an element of walking on eggshells, in case you push him over the edge I guess. Oh and that's another way I have described a lot of my relationship, walking on eggshells. Because when he was being violent, there was that, being very careful about what I was going to say in case he blew up. (Sabrina, lines 585-588)

These women offered a unique perspective on the process whereby partners may be affected, suggesting that in some households there is potentially an element of ‘primary’ as well as ‘secondary’ traumatisation. This is exemplified by Maria (lines 723-724) who constructed the violence towards her from her husband as being central to her own anxiety and hypervigilance (and thus her need to *walk on eggshells*), some of which – as in the extract above - seemed more deliberate and other occasions which appeared to occur in the context of one of her husband’s flashbacks: “Um (..) he's my trauma. His trauma is different to mine. Mine's being woke up and choked at three in the morning.”

Some of the women referred to a veil of silence which meant that the veterans did not talk much about either their military experiences or what they were struggling with in everyday life, which therefore kept them guessing and ‘on edge’ about the state of mind of their partner – again maintaining their need to *walk on eggshells*. Once the women heard more about the veterans’ experiences, this silence seemed to be re-constructed as something that was encouraged by the military system, which was seen as sanctioning against confiding in ‘outsiders’ and the potential leaking of state secrets. This is described by Thelma below, and Angela (lines 107-109), who stated: “I am of the belief that they are told when they come back that they sort of could talk about it amongst themselves but it wasn't something that was to be talked about.”

He said after the war they told him not to talk about anything that happened there, but to give a number, there was a card with a number he told me, if there is anyone else who asks questions give this number to them, don't talk about what happened in Iraq. (Thelma, lines 435-438)

The dynamic in the families tended to parallel this as many women reported that they kept the difficulties within the home, not wanting to share with friends or family for fear of being judged or misunderstood. This silence was constructed as propagating the process of *walking on eggshells* in a number of ways. In the absence of information from the veteran, some women assumed that they or their relationships were to blame for the problems, and therefore continued to do everything they could to fit in around the veteran:

I always thought it was about me and our marriage. Because he is not a big talker, it's really really hard to get any information out of him, and so I took it personally over the years... Always me. Always me and the relationship [to blame for the problems], what I say, what I do, I felt so bad. (Thelma, lines 53-55)

Others reflected that their own decision to not speak about family problems meant that they were not able to have the opportunity to learn that other ex-military families living with PTSD/trauma experienced similar difficulties, thus not realising there was an issue or that *walking on eggshells* had slowly become 'normal' overtime. Some were embarrassed about certain aspects of their relationships and anticipated others being judgemental and not able to understand. As a result, this strategy of colluding with the silence was understood by some women, as being unhelpful in the long-term and potentially maintaining the couple's difficulties through increasing their isolation. This is explained by Georgia (lines 305-306) who stated that "it's really hard to know how it affects you because you're living with it on a day to day basis and it's behind closed doors so no one else knows", and Caitlin:

And it's quite, it's also quite isolating because I would never tell friends or even my family what he's like. Cos for one it's not my story to tell and for two I don't really want people involved in our business if that makes sense. I can see why- it makes it even more isolating, because there is no bolt-hole for anybody to go to when it all gets too much. (Caitlin, lines 543-545)

3.5.2. My wounded soldier or a man behaving badly? This theme represented a central dilemma that the women were struggling with, namely, whether their partner was a 'good' man who was just sick and unwell or a 'bad' person who was acting in an abusive manner. This construction of their partners as either being sick or bad had a potent influence on how the women would consequently act and feel towards the veterans; it was acceptable to provide a sick man with care and nurturing, whereas if he was bad the probable conclusion would be divorce and for the women to acknowledge that they had married the wrong person. The fact that all of the women were currently still in their relationships at the time of the study - often requiring them to fight hard to have got to the point where they were - was almost definitely linked in part to the dominant construction across the interviews that the

veterans with PTSD/trauma were sick. However, it appeared that the women who had got to the point where they had communicated to their partner that certain behaviour was unacceptable to them, even if it was linked to PTSD, felt more secure and optimistic about their relationships. Although this idea of the men as being essentially good but behaving in a sick way was key in helping the women continue on their caring role, some of the participants acknowledged that this was not a static process and they often seemed to vacillate between the two extreme views in trying to work out their partners' behaviour. Maria alluded to a dominant social narrative about veterans being 'heroes' – a theme discussed later - which contributed to the times in which she switched towards feeling that she should be more idolising of her husband:

you swing wildly from like oh my God he's an absolute fucking cock-end and I can't stand him and he's awful maybe he hasn't got PTSD, he's just a twat (mm) to oh dear he's got PTSD, oh my God isn't it terrible, I should feel really awful for this bloke and go give him a kiss and a cup of tea and isn't it amazing, and he's a hero (Maria, lines 214-217)

Some women saw this split as being within the veteran, such that they had a 'good' and a 'bad' side, with the occasions that they saw the more pleasant elements of the veteran as being the reason they continued to stay in the relationship. Thelma (lines 88-90) recollected having to defend her decision to stay to her friends and family, who she felt had only seen or heard about the bad side of her husband's behaviour, and also that the dramatic switch between the two supported the notion that he had an illness: "they don't see when he's well what a great fantastic man he is, and what a fantastic father. So I always thought, you know this doesn't go together, the bad side of him and this good side". For Susie, the 'normal' times in between the more difficult periods was one reason she remained

committed, as was her construction of her situation as being preferable to other wives who might be living with a violent veteran partner:

Because the reason I'm still with my husband is that he is a good person. And I think if he was a drinker, and violent, I wouldn't be with him and I would have left a long time ago. But because I realise he has an illness, it's an illness that he has, and the fact that he is- he's calm. And in between when times are hard, we still go away for weekends and he does get on with the washing and things, so he is a good- I know he's a good person. And that's why we are still trying. (Susie, lines 81-85)

Receiving a psychiatric diagnosis, which for the majority included PTSD, was a significant event for most of the women in terms of their constructions of the struggles within their relationships. In some ways, it could be said that the diagnosis cemented the idea that the veteran was sick and therefore that the women should stay to look after him or be guilt-ridden if they decide to leave, as illustrated by Maria (lines 295-297): "I have no issue with the girls that leave, to be honest. Sometimes I am quite jealous, cos it's like, you know- but then you've got the guilt of you left somebody who was quite ill".

Women expressed relief that at least some of the undesirable elements of their partners' behaviour was now explained by a diagnostic label, meaning that it was not necessarily a permanent feature at the essence of the men's personalities:

And I didn't realise how many of his characteristics were relevant to the PTSD and the time he served, I just thought he could be an arrogant twat, but it turns out that there are lots of arrogant twats out there and there's a reason for it, that kind of makes sense... I was relieved because at least it meant he wasn't just an arrogant twat, there was a reason. (Caitlin, lines 45-48)

Not having received a diagnosis (or receiving one much later down the line) was constructed as a deficit and as impeding the women's ability to understand their situation. Some of the older women looked back on their earlier experience of living with combat-related difficulties, reflecting that the terms 'trauma' and 'PTSD' were not even in the professional, let alone public, domain at the time. This meant that they lived unsupported with the difficulties for a significant period, whilst their cries that something was wrong fell on the deaf ears of professionals who did not have a language to explain what the men were experiencing. For Veronica, she desperately wanted something to blame (other than believing that her husband had permanently changed as the result of his combat experiences) and for there to be an identifiable cure, thus constructing a diagnostic label as providing those functions:

because there is nothing to blame, because Jack hasn't been diagnosed with anything yet (mm) I have nothing to blame, and I think that if he came home and said "yeah I've developed a split personality disorder" I'd actually be quite happy because I'd think oh ok that's fine, that's why you've been so nasty and now you can go on tablets... at least I'd have something, I've got nothing to say well that's why that's happened (mm). (Veronica, lines 282-288)

Related to this, the *sickness* construction and associated diagnosis was also compelling in other ways, such that if the veteran was ill it meant he could be fixed or cured and also that he had less agency or choice over the nature of his behaviour, and thus was not to blame. This was more so for the women whose veteran partners were at the early stages of the process of receiving a diagnosis and commencing treatment, and who thus appeared to have higher levels of hope that these interventions would lead to positive change. Although receiving a diagnosis was in some ways a relief, it arguably also put more pressure on the women in terms of their role in caring for the veteran, as outlined in the *multiple roles* theme

below. Furthermore, some women spoke about their partners identifying too much with the idea that they were ill, by taking on a sick role which removed them both from taking steps to recover from PTSD, and the responsibilities of family and civilian life. In this sense, the PTSD diagnosis was constructed as serving a function for the veteran, which the women also felt themselves being pulled into in terms of the changes to their own roles within the family and relationship. This was described by Caitlin (lines 248-250): “He was almost proud to have a diagnosis ‘I can't help it I'm sick’. Well, yeah you may have a mental health issue but unless you start to help yourself you're never going to feel any better”, and Georgia:

I don't think there is anything in him that wants to get rid of it... He wants it there and he doesn't want to move on or move away from it because he's too comfortable. But this is my belief, I just believe he's too comfortable, with it, and why he's like that I don't know. It makes me think it's back to mummy's apron strings, it's a content place.
(Georgia, lines 496-501)

For those women who were in a relationship with their partner before or during his military service (and commonly prior to the onset of trauma symptoms), the sickness construction held particular significance as they could recall a time when their partner was well and ‘normal’. These accounts constructed a sense of loss and a grieving process for the husband that they no longer felt was there, to the extent that the new men were portrayed as being imposters. However in addition to being sick, these men were constructed as being essentially changed or damaged by their military experience, and some of the women were less optimistic that a cure would be possible. Miranda (lines 262-264), the eldest participant interviewed, constructed her sense of loss as being similar to the change in personality that may be seen in neuro-degenerative conditions, stating: “the husband's gone. I suppose it's a little bit like dementia, in a different way, you know, the husband's gone”. Other participants similarly reflected on their sense of ambiguous loss:

And it's it's a very strange thing to, it's a bit like I've grieved my husband and I have completely grieved him, so many tears and so many heartaches and (.) but he is still in the garden, looking like him (mm) and that's hard because (yeah) if someone dies they die and go don't they, like my dad did, and you grieve and move on and but you are kind of in this massive limbo because he is there but it's not him, and will he ever come back (mm)? (Veronica, lines 168-190)

It's as if this person who is Paul isn't Paul is a stranger to me, he's not the person I married, and I've said this to people but a lot of people can't understand that but when you-you think back to that time and I look at him now and I think well you're not even there anymore and it's because this has taken him over so much that it is living, and he's not a normal person anymore and it breaks my heart to see him like it because I just feel as if this is all in his mind but it has taken over his body as well, it's taken him over completely (Jane, lines 70-75)

Some of the women who had children spoke about a similar process whereby their children were aware of their father's difficulties and wanting them to get better, thus similarly constructing them as being sick. In addition to saying, like Elizabeth's daughter that: "I just want my old dad back" (line 497), children were also observed to take on a caring role or become overly-protective and defensive of their father, highlighting the systemic influence that trauma can have on the whole family system.

Some women had not heard the veterans' trauma stories until later down the time, but this was constructed as being a turning point in terms of helping the women give meaning to the veteran's behaviour. Instead of this being a distressing experience for them, it helped them to have more empathy and understanding for their veteran partner, and again facilitated their construction of their partner as being sick or damaged:

I knew he was diagnosed with PTSD, but because we never spoke about it, we didn't understand it. And I thought well why has he got it? Because all I know was that he would go out to work, we used to joke he was playing action men. I very much regret saying that to him now because of some of the things that he's seen and the things he's been part of, and the fact that four of his friends were blown up. (Susie, lines 28-32)

Here, women also referred to the difference between physical and emotional injuries received in service in constructing their experience of their partners' difficulties. They reported an awareness of the hierarchy of injuries within military culture and society at large - which they felt put mental health difficulties squarely at the bottom - and suggested it would be easier to deal with if their partner had lost a limb rather than having an invisible problem like a mental health issue. They felt that society would understand this better. Many women did not speak to their friends or families about the mental health difficulties because they expected people to judge them for putting up with bad behaviour, meaning that outsiders would not sign up to the idea that the veteran was sick:

it's not visible so people can't see what your problem is. And that makes it so hard... The problem with the PTSD is that you can't see what is going on, it's almost as if it's a hidden illness that he can just forget he's got. (Hilary, lines 439-442)

And a lot of the time, I wish he had lost a leg or something because I know these guys probably will have PTSD too, but you know people can see there's something wrong. You know whenever you see these Help for Heroes things and stuff you know they always show people who've lost legs or arms you know. (Elizabeth, lines 563-566)

Related to this, some women, such as Elsa and Elizabeth, acknowledged that they thought their approach towards their husbands would be more sympathetic if they had received a physical injury, in that it would be easier to care for them and have a visual

reminder of the disabilities they had suffered in combat. Elizabeth had this experience when her husband had to undergo an operation, noticing that she changed in how she treated him and he in turn responded favourably. She later constructed this period of time as in some ways realigning the power imbalance that had developed in their relationship, as it felt they were working as a partnership in carrying out the medical tasks he required:

when he was ill for those few days and when he came home with his catheter and I was- because he was physically ill, I think possibly I changed towards him, I think that I possibly was more caring or-or nurturing or something, and he responded to that and was you know- he was talking to me a bit more and saying I do appreciate what you're doing and I do love you, and it was quite interesting the difference, because he had a physical illness you know. Erm and I think that made a big difference... all of a sudden he was reliant on me physically, so even like washing, changing the bag, all of this erm I suppose we were a bit more of a team. (Elizabeth, lines 802-815)

I know that he's ill so it's a catch-22 sort of situation, because would I be horrible to him if he was in a wheelchair and he'd had his legs blown off in an accident, I wouldn't, I would be like, well I can see the legs blown off he's ill he can't walk. But you know he's got a mental health problem and mental health problems are real. And they're an illness, you know. (Elsa, 278-282)

Angela spoke about awareness of a societal disregard for the emotional impact of serving in active combat, referencing a dominant narrative that war disabilities involve loss of limb. This invisibility of PTSD/trauma was therefore understood as impacting the women's experiences of living with combat-related trauma both within their family systems, and within the wider cultural context, as they had to contend with a society that they constructed as not understanding their situations or that their partner was ill:

when they are out doing tours, you hear about those who have died, and you hear about those who have been injured um, when they get their medals you see the ones like amputees and things like that but you never really hear any mention of those with PTSD or anything like that. So I don't think people are really aware that it is as big an issue as it actually is. Because there's just not, I think its lack of awareness really. I guess they probably think that if they come back with all their limbs then they are okay. They probably don't sort of see the other side to it (yeah). (Angela, lines 303-308)

3.5.3. “Being somebody’s wife, mother, nursemaid, champion”: Partners’

attempts at negotiating multiple roles. The women all constructed their experience of living with trauma as demanding that there was a shift in terms of the roles they occupied within their family, and their relationship. This included feeling like a carer for their partner, which was strongly linked to the themes above about the veteran being *sick* and not able to fully function within the home, and also *subduing their own responses* to care for and make life as easy as possible for the veteran. Fulfilling a carer role involved a number of responsibilities such as organising their partner’s daily routine and encouraging them to be active, assigning them tasks to do around the house, ensuring that they eat, take medication and go to bed on time, filling in benefit forms and compensation applications, providing a listening ear or trying to encourage them to talk about their worries. This change in role left some women, such as Mary, confused about their status within the couple, but taking on a more directive stance was constructed as being necessary for the continuation of the relationship. For Hilary, actively embracing the carer role was constructed as a defence against the painful alternative that there was nothing she could do to help her husband, and to prevent the difficulties affecting her on a deeper, more personal level:

It's um- because I started in health in the NHS, I kind of go into professional mode, so it's almost like I'm at work, on call. Because that's my coping mechanism for seeing my husband sat there in tears, knowing that I can't go and hug him because he'll lash out and he'll hurt my wrist, he'll grab out and it will be painful (Hilary, lines 149-152)

that's been a really difficult battle cos it's a funny role to play cos it's not really mummy, it's not really care-ish, it's really not girlfriend... but I always knew that if I didn't battle on with some of the really trivial things like... you need to get up because I want to have a relationship with you and if you get up at one and go to bed at five am, I can't have a relationship with you because I won't see you. (Mary, lines 659-665)

The shift in roles was generally constructed as a process that occurred gradually over time, with some women suddenly realising the extent to which they had taken on carer-like duties. This was often accompanied by a change in some element of the power dynamic within the relationships, with the veterans' withdrawal from family life meaning that the women had to take charge. All of the women observed this change to some extent, with it seeming to have become more of an entrenched pattern for those participants who had lived with combat-related trauma for a significant number of years. This shift in relational roles was constructed as being an undesirable situation, with many of the women wishing that it felt more balanced and that they were working as part of a team:

that didn't happen overnight, that happened very gradually um cos it wasn't really something that I was expecting to do, it was just one day you kinda wake up and think God he doesn't go anywhere without me. He doesn't do anything without me... it wasn't a role I really wanted, it was one that was just sink or swim, do it or leave...

Yeah an uncomfortable role of being somebody's wife, mother, nurse maid, champion of kinda information (Maria, lines 178-185)

Actually there was one time I was actually his carer without even realising I was his carer... there was one particular time it was horrendous, he wouldn't even get washed. He couldn't- he wouldn't even eat, I had to run the bath and say get into the bath, have something to eat, making sure he had clean clothes on (Susie, lines 67-71)

In constructing their experiences, some of the participants took a critical stance towards dominant social narratives about the responsibilities of wives (to stand by their husbands wherever possible and sacrifice their own needs if required, with military wives being a more extreme version of this) and gendered role expectations that women should provide care and look after the household. For example, Thelma (lines 493-502) stated that “everything in the Army is all about how to support your husband, don't be a bad wife and make dramas... you know all these sacrifices but you don't get information back, nothing”, and Georgia referenced generational differences when constructing her husband's approach to domestic life:

he's come from an era of people that it was from his forefathers, his parents, it was a women's job to run the home. But also it's the same era that women started working, so it's also perfectly acceptable for you to go out and work as well. So here you are, you're running a home and you're working, and he's sitting down with his feet up because he's signed off work, you know. (Georgia, lines 602-605)

In addition to the carer role, other ways the women commonly constructed their position within the couple was to compare it to a mother-child relationship, or as if they were a higher ranking soldier giving orders to their subordinate. Similarly to being a carer, what these alternatives all had in common was that the woman was positioned in the more

powerful, responsible role. With that positioning though, meant that the veteran was by default not reciprocating in terms of providing support back to the woman and family, which potentially was both a cause and a consequence of the power imbalance. The mother-child relational position was particularly aversive to the women, with some disclosing an associated reduction in emotional and sexual intimacy, and that they now had another child to parent, rather than someone to parent with them:

I felt that he was like another one of my children. I felt that he was a child. And that was another thing about the dynamic, I didn't want to be with a man who was like a burden to me, or like my child, I needed an equal. I wanted a partner... And I think also I became a bit sergeant major in my approach to life. Because to cope with the amount that I had to cope with, I had to be quite organised... And he liked to take orders and instructions and I realised that that was the way to manage him, eventually. (Sabrina, lines 341-453)

So I just, I don't want to be his mum, I'm not his mum. I mean his mum died some years ago but, I don't- I'm not a replacement for her, I want to be his wife but I'm not his wife in many many ways, even when it comes to the intimate side of the relationship, we haven't got one. Because he doesn't want that, so that to me just makes it another mum child scenario if you like, I don't know how else to describe it and I find it quite embarrassing to be honest (Jane, lines 215-220)

For the women with children, the shift in roles included them working hard to protect their children from their father's difficulties. This typically involved the women compensating for what their partners were unable to do, which was constructed as a necessary double-parenting to try and shelter their children from fully realising the extent of their father's difficulties and to not be disadvantaged by the situation. In Veronica's case, she

constructed this strategy also as a way to prevent her husband and children's relationship from being damaged; however, her struggle with this increased once as she realised that his illness was not as temporary as she originally thought:

So I kinda ended up double parenting (right) so that they didn't think badly of Jack, and so they weren't put in the situation where they might be criticised or they might feel feel this kind of thing going on, because I didn't want that to happen because I thought it would get better (Veronica, lines 37-40)

The impact on children was an emotive topic for many, as despite their best attempts, a number of the women spoke about their children having emotional difficulties and requiring professional support. In Miranda's case, she realised on reflection that her (now adult) daughter was more aware of the difficulties during her childhood within her parent's relationship than Miranda appreciated at the time. Thelma also noticed how attuned her young son was to his father's moods and that this consequently meant there was some mirroring between the moods of the individuals within the household:

Erm the biggest person that is affected is my daughter obviously. She's had all this- she's lived in an unhappy marriage I suppose and er it has traumatised her and she's having um help, she's having counselling. She has on a few occasions, well on a lot of occasions said that she wanted to commit suicide and she went for help when she was about twelve, thirteen and she actually told the counsellor that her dad was an alcoholic and it hadn't even crossed my mind at that stage. (Miranda, lines 316-322)

When we pick up the children we often do that together... so then if I come alone sometimes, my son will ask 'where's papa? Where's dad, is he not feeling well? Are we coming home, is he sleeping?' And then he is down, he is frustrated as well. (Thelma, lines 214-217)

Many of the veterans with children were constructed by their partners as having a less than optimal approach to interacting with their children, as a result of their PTSD/trauma. This involved either an overly disciplinarian, critical and controlling stance, or one where they were absent practically. The women realised that many elements of parenting were very challenging for their partners at that point in time, but again felt that it came down to them to manage the interactions within the household, as they did not want their children to be affected by it. For Caitlin and Veronica, this involved a watchfulness and stepping in when their husband did not respond to their sons' requests, pre-empting the difficulties and having an alternative planned:

I'm watching all the time. I knew this morning when I was in the kitchen, doing the dishwasher while on the phone, I knew that he wasn't going to play cakes properly. And lo and behold, "mummy please play cakes with me mummy please". Interact with your son! What is the matter with you? (Caitlin, lines 571-573)

I'll know what mood Jack's in so if Bobby asks him to do something I know it's going to be a no, so I'll say "oh dad's a bit tired today, cos uh with working the last three nights", and then get him out before I have to say anything else, then I take him off out. Because (.) I don't want him t-, I don't want him to think that his dad doesn't love him, and I know that Jack does but until Jack gets better (.) it can do a lot of damage to children's own self-esteem (Veronica, lines 318-322)

In addition to being absent from the practical duties of parenthood, some women noticed an emotional absence too which impacted the veteran's ability to bond with their children. Angela particularly noticed this following the birth of their first child and it highlighted both the practical and emotional roles that her husband appeared to be unable or unwilling to take responsibility for:

that was definitely the hardest part, the first nine months because there were times that I felt like I was bringing her up on my own. Even though he was here he would just sort of do anything- like he would have a cuddle with her but he would try to do anything to avoid actually having to have any responsibility as such, you know bathing her or feeding her... Um yeah so I just thought that was strange but at the time I didn't realise that it wasn't normal behaviour. (Angela, lines 351-358)

Central to the shift in roles was the concept of over-functioning, whereby the women compensated for what their partner was unable to do by taking on additional roles, including those they had previously constructed as being 'a man's job'. For some, this meant that they were unsure as to whether the veteran had any household role left, but were unwilling to relent some of the responsibilities due to the perceived impact this would have on family life:

well I just kind of, I just do everything. I just don't really assume he can do anything... it's really hard to get a balance because once again I could try and give some like control if you like back to Mark but then everything goes pear-shaped and I can't take that risk because everything's so difficult anyway. Erm and I think he's- he accepts that. (Elizabeth, lines 4521-524)

Some women assigned their partners certain roles around the house, which was found to be helpful in some cases, although others felt this worsened the veteran's distress and therefore the emotional load on the women. Others noticed that their partners were aware of this shift too, and were conscious of wanting to avoid prompting any further withdrawal in the veteran. Arguably, the women's best intentions in increasing their input within the family may have been linked to the veteran's further withdrawal, as some veterans appeared to want to hang onto particular roles as if it was crucial for their identity and place within the home:

Now he-he stopped cutting the grass and it got really really really long but I wasn't allowed to cut the grass, because I was going to be taking another one of his jobs

away from him. He'd got this thing that when he came out of the Army, I took away all his jobs (.) I didn't, because I actually wanted him to do more. (Veronica, lines 414-417)

I don't think you could take that [driving] away from him because he's actually in control of something there, as his little domain and I can't take that over and he knows that because I can't drive. (Jane, lines 362-364)

The women also took a lead role in organising professional support for their veteran partner and this was commonly constructed as being in limited supply and hard to get. Acquiring the appropriate support was seen as being essential for the future of the couple relationship and family, as well as the individual. However, women often felt excluded from the support when it happened, which was hard to deal with given the carer role they had come to fulfil, but on the whole knowing the veteran was receiving treatment was a huge relief. It felt like someone else was taking some responsibility for the care of their partner, and for some, linked into the previous theme that their *sick* partner was at last starting the journey to recovery.

For others, the whole process of being a carer and an advocate for their husbands was constructed as being a battle that the women were responsible for fighting. This was associated with regret and anger that the military and society did not seem to fully appreciate that the effects of combat-related trauma/PTSD were potentially long-lasting for the families of veterans, in addition to the primary trauma survivor himself. This is summed up by Hilary (lines 549-550) who took on the role of fighting for professional help: “he just isn’t able to fight for it, which is what I end up having to do. And I shouldn’t have to fight for services”, and Jane who despite caring for her husband for over twenty years, still felt that she had to battle her way through the financial and health systems to support both her and her husband:

Paul's done his bit, I'm paying the price now, sounds selfish yes I know it does but I'm paying the price now for what he did, so I'm still fighting for this country to try and keep him going as much as I can. But like them, you can only fight for so long. You can't keep on and on and on because in the end you think right I'm going to give up. I can't be bothered anymore. And I have got to that stage but somehow I've just got back up there and I've started all over again, the fight. I do give up but nobody's going to give us anything, I've got to get out there and fight for it but I'm still fighting for the two of us. Not just fighting for one, it's both of us I'm fighting for. How long? (Jane, lines 653-660)

For the majority of the women, the consequence of juggling multiple roles, over-functioning, trying to encourage their partner to participate in family life, and fighting for support not surprisingly led to them feeling burnt out and struggling with their own mental health difficulties. This situation was constructed as being a significant factor in how they personally were impacted by living with combat-related trauma, as their difficulties were seen as being directly linked to the veterans' issues:

It has just been incredibly wearing and I think it just finished me off, so yeah I ended up seeing the doctor quite a lot um and just the fatigue was just immense, so yeah they are treating me for chronic fatigue now, and then depression, what a surprise, cos I guess it has to rub off at some point, there are very few people who are totally immune to it all and I think I just got y' know engulfed in it all (Mary, lines 153-156)

Sometimes I'd go to work and I'd be a complete wreck. Just because everything is too much and it's just so overwhelming, just trying to deal with your own stuff let alone trying to deal with someone else's problems as well, who is reluctant to deal with them. (Karen, lines 348-350)

For some, this resulted in them seeking their own mental health support or deciding that something needed to shift. In situations where the veteran was not already seeking treatment, this often involved the women giving them an ultimatum that they needed to change and to attempt to realign some of the role imbalance within their relationship:

And also the other analogy I had was rowing a boat. I kinda felt that our relationship was me doing all the rowing and him just laying back, like a huge heavy man. That was kind of, I felt that kind of burden... I'd say look I need you to help me, I need you to row the boat with me... I need you to be doing things to keep us going. (Sabrina, lines 588-592)

3.5.4. Heroes don't do the dishes: How constructing veterans as heroes impacts the maintenance of PTSD/trauma and family difficulties. The women were aware of a dominant social narrative that positioned veterans as heroes and employed this to construct their experience of the impact of combat-related trauma within their families. Commonly, this narrative was denigrated and rejected as being harmful to both them and their veteran partner. It was constructed as putting veterans on a pedestal and giving them an excuse to avoiding the menial chores of family life, such that these jobs would be incongruent to someone who was wanting to maintain the sense of being a hero. Caitlin added to this by constructing her husband's identification with being a hero as potentially contributing to his difficulties, by increasing his isolation and inability to fully integrate into civilian life:

"I've done seven years for Queen and country", we're talking about a fucking dishwasher, I'm struggling to see the relevance here... He does have a superiority complex because he's done seven years for his Queen and country, it does mean it puts him a couple of rungs above everybody else. And the unfortunate thing is, is that nobody else out there sees it like that. So I wonder if that's what makes him even worse, wanting to wear it even more as a badge. I mean he literally would walk

around with a badge on saying it to be honest. But nobody- as I just said, nobody out there really seems to give a damn. (Caitlin, lines 127-137)

yeah hero doesn't want to go shopping in Tesco's and sometimes it's not because it's an ordeal because it's busy and whatever, it's because he's feeling a little bit in the hero balloon and now thinks that's a little bit beyond him (Mary, lines 443-445)

Other women also alluded to the ignorance of wider society and the role this plays in propagating the *heroisation* of veterans. Outsiders were seen as seemingly unaware of the potential consequences of warfare – not just for the soldier himself, but also for his family. Some women referenced the media's role in painting an idolised image of the military, and constructed this as having an impact on their own experiences of living with combat-related trauma. Specifically, they spoke about their annoyance that people expected them to be the dutiful wife and to do all they could for their hero husband, which perhaps prevented the reality of their home situation being acknowledged or appreciated:

and you know there is a lot of this Help the Heroes thing going on, help the soldiers and lots of documentaries about helping the soldiers, and there is no documentaries on army wives (mm), well there is nothing is there, so everybody feels sorry for the soldiers and "I hope you're giving him lots of support" and-and you think you have no idea, or we wouldn't be having this conversation right now, you'd be thinking maybe more like God that's awful, they don't give any of them any support you know. But I think it's all very in the papers about the actual men, nothing about the people behind them that are getting the abuse and the rubbish to pick up. (Veronica, lines 730-737)

Oh for God's sake, November is just-just the worst time because everybody is wearing poppies, telling everybody they're a goddamn hero and you're like yeah that's just great thanks, you have absolutely no idea what my life is like! (Maria, lines 227-229)

And the parents go "oh I'm so proud of my son, he's in the Navy, doesn't he look so fabulous". They're not so proud when his legs are blown off or he's suffering, he's beating his wife up shouting at his kids. That's not fun is it? (Elsa, lines 166-168)

The impact of the hero narrative on the men themselves was constructed in multiple ways. In one sense, it was regarded as being potentially adaptive and helpful at the time the men were serving, as it helped them to have the upmost confidence in their abilities and thus facilitated them being able to carry out such a difficult job. Alternatively, others constructed the heroisation of military service personnel as being silencing, preventing their veteran partners from being able to show their vulnerability and seek help; as heroes are by definition strong and not in need of talking and support. Thelma alluded to an idea that silence is promoted by the military for a variety of reasons, and the heroisation of soldiers is employed to encourage this:

I believe that is how they train them to be, to be- keep it a secret, be proud of it what you've done, you're a man you're a tough soldier, you're a hero, they always call them heroes all the time. (Thelma, lines 481-483)

...it's instilled in them that they are great, because how else would they be able to do their job if they didn't think that you know, I mean there's no room for manoeuvre when you are doing a job like that is there. (Caitlin, lines 169-171)

Some women constructed the hero narrative as being fragile. Whilst it perhaps served as a psychological defence for some men, for others it was incongruent with how they perceived themselves and overshadowed the complicated feelings they felt about particular elements of their combat experiences. Thelma reflected on this and noted that she herself had become caught up in the taken-for granted heroisation of her homecoming husband, which she later constructed as being unhelpful and minimising of the distress he was actually experiencing:

...how does it go together, you call someone hero but him himself feels like a murderer. You know what I mean? It's understandable isn't it? And then as wives you've been standing there with your tee-shirts hero welcome home yeah, but they don't feel like heroes. And now I look back and I think how stupid, you know.

(Thelma, lines 483-486)

I mean it's that whole thing (..) kids tend to do it don't they "so have you killed anybody", but it's not really something he is proud of, it's been a job... yeah I think there is an awful lot of him feeling like he will be judged by people that he'd been you know this foul person and done things that he shouldn't have done. (Mary, lines 331-337)

On the other hand, a number of the women were more aligned to the construction of veterans as heroes and their anger was directed towards a society who did not appreciate the sacrifices that their partners had made for the country. In this sense, they spoke about their frustration that society was not signed up *enough* to the idea of veterans as heroes, which potentially left a space for alternative, less desirable, narratives to be expressed.

I don't think they get enough credit, but then I didn't have that um opinion before we got together because I don't think people are aware of what they do and you know, the sort of thing that they have to go through until you're in that situation, I don't think you can really understand. (Angela, lines 282-285)

I also feel very angry to the general public, even though it is changing now and they are um more aware of what our boys do abroad and that. Um but I don't think um the general public realised what the theatre of war in Ireland was like. Erm I think everything was taken so much for granted (Miranda, lines 339-342)

Some women were angry that the military-focused intervention for PTSD/trauma appeared to reinforce being a hero and re-institutionalised the veterans, rather than preparing

them better for family life. They were cynical of treatment centres that mirrored Army barracks, where meals were prepared and beds made for them, and where they lived once again within a military culture. In Georgia's opinion, support of this nature fed into the maintenance of her husband's PTSD as it served a function for him to be able to preserve his attachment to some element of the Army. Mary cautioned against input that encouraged the continuation of veterans' self-construction as a hero, as an unintended consequence of this was that it removed them further from family and civilian life, thus impeding their reintegration:

I think there is a real danger if they are not careful, of creating this sort of hero culture (mm) and people feeling entitled... I see a lot of the guys you know we are trying to help them with vocational employment stuff and they seem to think that, because they have been cocooned by the charities and things you know "aren't I amazing because I am a hero and I wear my hero tee-shirt and I am telling myself I am a hero every day and everyone tells me how amazing I am, that um I don't need to do a job application like everybody else I think someone's just going to give me one" (mm). No! Doesn't really work like that! (Mary, lines 368-375)

And he just feels, to me, like he's part of an elite group that are regarded with attention and pity, and he's a hero. All these things that come into it... I almost feel when he comes back [from a period of treatment] that they've swaddled him up in cotton wool and just going there you go. And I think I don't want him like that, I want him with his feet running ready to mix in with this family life that he's living with... 'cos you know he's shown me a painting he's done, 'cos painting is a very good therapy that they use, and I'm thinking why can't you come home with a cottage pie or something that you've made, you know what I mean. (Georgia, lines 156-169)

Within this theme, women again referenced an awareness of a hierarchy of disability within the military, which had a significant impact on the way that their veteran partners constructed their difficulties. The women often took the role of reminding their partners of the validity of mental health issues and that they were as deserving of help as their counterparts who had lost limbs:

because he will say that there are people worse off than him. And because he hasn't lost a leg and he hasn't lost his arm, he thinks other people deserve things more than he does. But I have to remind him that it's his mind (Susie, lines 143-145)

...and he doesn't see it as a disability. I ticked a disabilities box and he just said I don't have a disability... and he just could not accept it. Because his view is someone who has lost limbs. From whatever conflict or whatever situation, not someone who has a mental health problem. (Hilary, lines 431-435)

Mary spoke about the interaction of this stigma with the hero narrative, such that if an individual had an invisible war disability, they had to increase their investment in being a hero to ensure that they received merit from their peers and support from charities:

There is a definite hierarchy (.) so if your legs have been blown off that is er (..) that's like the proper hero, that's like one hundred percent hero, if you've only got you know your hand missing you might be seventy five percent hero, if you've got a non-visible injury or ailment then you're sort of down in the twenty percent, thirty percent and that's when the war stories start getting more grand because they almost sort of fight their way into being worth the charities' effort (Mary, lines 481-486)

Some women referenced the history of combat-related trauma when constructing their understanding of their veteran partners' perceptions of having PTSD. Specifically, they spoke about soldiers, who nowadays would be constructed as having PTSD, being shot for cowardice during the First World War. This alluded to some awareness of the impact of time

and place on how psychological distress is constructed within society, and also that some of this legacy appeared to remain and perhaps contribute towards the current stigma associated with combat-related mental health difficulties.

3.5.5. “The Army were his family”: Struggling with the transition to Civvy

Street. The women noted that an additional complicating factor in the expression of combat-related trauma was that their partners were also struggling with adapting to civilian life since leaving the Forces. They were generally constructed as being ill-equipped for family and civilian life, with common themes including that the veterans were controlling, had OCD-like neatness, were unable to make their own decisions, and wanted to follow strict routines. The women reasoned that some of these characteristics may have been extremely adaptive in the Armed Forces (e.g. to follow orders rather than making their own decisions), but became problematic when transferred to living in a family. Having PTSD on top of these characteristics was seen as amplifying the extent that they were difficult to live with and as making change more difficult:

- and they don't know how to compromise, because they don't need to compromise, they just need to go and fire their gun when they are told to and tell someone else what to do. So they have had this whole twenty-two years, this whole brainwashing experience and then they can't deal with it in their family life, because there is no compromising... where that's what you need to do with children. (Veronica, lines 351-355)

They haven't got a clue how to behave in Civvy Street. They still go to the pub, they still get drunk. But the thing is when they sober up, you've still got to think for yourself, you've still got to go home and you've still got to decide what you want to wear, where you want to go, what you're doing. You're not going to have a man

bellowing at you saying right you're going to do this this and this and you go off and do it. (Jane, lines 587-591)

Some women constructed military experience as permanently changing an individual, purposely brainwashing them and taking away their autonomy. Veterans were also seen as being essentially different from civilians and operating by a different code. This linked to the theme of *negotiating multiple roles*, as the women felt responsible for trying to teach their partner the skills they required for civilian living, of which some women questioned whether their partner had ever had the opportunity to acquire due to the young age at which they joined the Forces. This was described by Veronica (lines 552-554) who felt that “they've been made, it's like a robot they've all been installed with all these programmes but they're never installed to come back out into normality”, and Elsa:

The first six weeks is when people tend to leave, I don't know if you've got the statistics, but it's quite high. They say they try to sort the men out from boys, but I'll tell you what I say, they're trying to sort the robots out from the thinkers, you know. (Elsa, lines 378-380)

The women consequently felt angry that the Ministry of Defence (MOD) had not taken responsibility for retraining veterans to be able to fit into society, and felt that both society and the MOD forgot veterans once they had served their purpose. Some women constructed this sense of being overlooked as being exacerbated by military budget cuts and the large number of veterans presenting to services. In this sense, they referred to current narratives about austerity and limited resources as another reason that they and their partners were left without the support they needed:

all the cuts in the Forces I'm not sure have been a good idea, because that's putting more pressure- and the thing is when they do come out, there are no jobs there for them either... but they have got to put more into them when they do leave, not just

dump them and leave them and run away and shut the door on them, because that's when all the problems do start. (Jane, lines 613-619)

I think it's just disgusting how they basically have given everything for their country and they're just discarded... it's just unreal. It's almost like brushed under the carpet... when I spoke to Rob's CPN she said there was initially a view to support wives and families, but the demand to support veterans was just so so high, they just can't- they can't even see all of them. I mean his CPN said all of those who are on that tour in 2007...she sees practically every one of them soldiers. (Karen, lines 290-295)

There was also discussion of the multitude of losses that veterans experience when leaving the Armed Forces, which was seen as a triggering factor for their PTSD/trauma symptoms. This included the loss of employment, structure, routine, friends, respect and authority, and a sense of purpose. Additionally, the military were constructed as fulfilling the function of the veteran's family, providing structure, containment and support which was a major benefit of serving in the Armed Forces:

he had that release where he would go out and go down to the mess and relieve stress with mates in the Army, he doesn't have that any more. So it's almost as if you've been removed from the whole support network, essentially family (Hilary, lines 583-586)

...the Army were his family. And then when he left the Army and he tried to make contact and people just didn't reciprocate, he kind of lost that. So I think that's hard because it's sort of dealing with a loss (Angela, lines 129-131)

Some women took the idea further of the military as a surrogate family, constructing the system as providing an attachment figure or *secure base* for their partners throughout their formative years. In this sense, transitioning to civilian life in a way represented a painful

separation from a structure that they had come to rely upon. Some of the women acknowledged that their partners had certain pre-existing vulnerabilities which for many of them was the reason they joined the Forces in the first place. This included the desire to escape an unhappy family situation where there was domestic violence or alcohol abuse, or to get away from dysfunctional relationships with parents:

And sometimes he'd be talking and just say "oh Serge would be really happy with you for that". Like I do things and he'd be like "whoa yeah, you'd make Sergeant really happy". And of course sergeant to them was their dad, daddy figure, when they were being trained... in many ways Adam said he had to get away, he didn't have any options to stay at home, he didn't have anywhere to go... But he found a new family, when you talk about sergeant being the daddy-figure almost, and all your mates are part of your family. (Sabrina, lines 443-450)

Some women disclosed that their partner had suffered abuse when they were younger, had anger problems or were 'acting out' in some way during their adolescence, and constructed these early factors as contributing to the veteran's present mental health issues. In this way, these women captured some of the complexity in understanding emotional problems, as the events that occurred in combat were constructed as being just one part of the puzzle in making sense of the men's difficulties, rather than solely to blame.

3.6. Chapter Conclusion

This chapter outlined the collated demographic information of the individuals who participated in the study, and provided pen portraits of the individual women. . It also provided an in-depth exploration of the five themes, which suggested that the women and constructed a number of significant ways in which they, their families, and their relationships, were impacted by combat-related trauma.

4. Discussion

4.1. Chapter Summary

This chapter summarises the findings of the current research, and discusses how they relate to the existing body of literature. Clinical and research implications are discussed, as are the strengths and limitations of the study. This chapter concludes with a reflective summary of the researcher's experience of completing the study, and how her own position and views may have influenced the research process.

4.2. Summary of Findings

This study provided, to the best of the researcher's knowledge, the first qualitative investigation into how partners of UK military veterans constructed their experiences of living with combat-related trauma carried out from a social constructionist perspective. The resultant five themes co-constructed an understanding of the relational, emotional and practical complexities the women and their families were living with on a day to day basis, and the influence of social narratives on the way they made sense of their realities. In summary, the women constructed a process of *walking on eggshells* and subduing their emotional and behavioural reactions as being necessary to manage the level of emotional expression within their families and to try and avoid conflict or the triggering of their veteran partners' PTSD symptoms. They commonly alluded to a dilemma in deciding whether their partner was *a wounded soldier or a man behaving badly*, the result of which consequently meant they either needed to become more caring or nurturing, or alternatively to give firmer boundaries and perhaps leave the relationship. The women were engaged in *negotiating multiple roles* within their relationships, which had tended to gradually shift over time to one where they were responsible for the majority of the tasks of family life and had come to take on a carer/parent role in relation to their veteran partner. The theme centring on how *heroes*

don't do the dishes described the powerful influence of social narratives about veterans, warfare, and the military and how these infiltrated family life, perhaps even contributing to the maintenance of PTSD/trauma. Finally, the women constructed the transition from the Armed Forces as representing a significant challenge for their veteran partners, one which was associated with multiple losses as "*the Army were his family*". Each theme contributed to answering the three strands of the research questions; that is, how partners of veterans constructed: their experience of living with combat-related trauma; the *process* whereby they were impacted; and the influence of wider social messages on their own experiences.

That the women felt it necessary to *walk on eggshells* has been reported elsewhere in the qualitative literature exploring the lived experiences of veterans' female partners in other countries (Verbosky & Ryan, 1988; Outram et al., 2009), which was similarly understood as a way to prevent escalation of anger and conflict within relationships. Additionally, participants in the current study also reported wanting to protect their veteran partners from having to deal with the difficulties of everyday life and repressing their own emotional responses as a way to cope with their partner's unpredictability, which are also findings which have been reported elsewhere by female partners of veterans (Frederikson et al., 1996; Lyons, 2001). Arguably there are parallels between these responses and those described in theories of domestic violence, such as Walker's Cycle of Violence Theory (Walker, 1979), where it is posited that the 'victim' acts to lessen build-up in tension preceding the 'abuser's' aggression by using a range strategies such as avoidance, subduing their own reactions and sometimes prompting an argument before their partner does to regain a sense of control. Walker's model also highlighted that periods of calm in between more challenging/abusive times within a relationship can make it difficult to leave and simultaneously provide a reason to continue to invest in the relationship. Indeed, many of the women in the present study mentioned the 'good times' as being one reason they remained committed to their partners,

which for most, happened regularly enough for them to be able to recover from more catastrophic moments. Rather than physical violence (apart from for two of the women in the past), the crisis points in this context tended to be worsening in mental health difficulties, periods of extreme withdrawal, or emotional and verbal aggression.

The women described finding that their partners' anger was their most dominant emotion, the expression of which they were keen to avoid. Other researchers have noted the higher levels of expressed anger in veterans with PTSD compared with civilian PTSD sufferers (Lambert et al., 2012) or when compared to veterans without PTSD (Taft, Street, Marshall, Dowdall, & Riggs, 2007) and asserted that it can have a detrimental impact on couple and family functioning (Ray & Vanstone, 2009). Some have suggested that a reason for the predominance of anger may be that showing psychological distress through 'softer' emotions would not have been adaptive in military and conflict environments (Nelson & Wright, 1996), therefore anger becomes the default position. Biddle, Elliott, Creamer, Forbes, and Devilly (2002) reported that anger was highlighted as the most problematic issue by both veterans diagnosed with PTSD and their partners, and tended to be the precipitant to seeking professional treatment. Those working with veterans and their families may therefore wish to explore the meaning and impact of anger within the family system and encourage the expression of a broader range of emotions.

Difficulties in the reciprocal expression of emotions was apparent throughout the women's constructed stories. They referred to their partner's inability to tolerate emotions in other people and their withdrawal from situations where they were expected to comfort their wife or girlfriend. This meant that the women generally stopped approaching the veteran for emotional support, consequently leading them to feel that there was a lack of intimacy and reciprocity in their relationships. Emotional numbing and avoidance is a defining characteristic of PTSD as denoted by the *DSM-IV-TR* (APA, 2000) and, as described in the

introduction section of this thesis, has been found to be related to reduced relationship satisfaction in both quantitative (Cook et al., 2004; Goff et al., 2009) and qualitative research studies (Frederikson et al., 1996; Dekel et al., 2005a; Outram et al., 2009; Nir et al., 2013). Of course, when positioned within an intimate relationship avoidant behaviour will have an impact on how the other individual within the dyad will react. It could be said therefore that the women's strategy of walking on eggshells was in itself avoidant and in some situations unhelpful (albeit useful in others), perhaps even contributing to the maintenance of the difficulties. This unintentional reinforcement has been noted elsewhere (Monson, Taft, & Fredman, 2009), although it seems important that this is approached sensitively when working with couples living with combat-related trauma. Additionally, the avoidance cluster of symptoms was also seen as particularly problematic for parent-child relationships, meaning the women constructed one of their *multiple roles* as 'double-parenting' to protect their children from feeling rejected. Again, this finding has also been reported in other authors' accounts of veterans' family functioning (Ruscio et al., 2002; Galovski & Lyons, 2004) suggesting that families may require particular support in understanding and overcoming this element of living with PTSD/trauma.

As a consequence of subduing their own responses and feeling unsupported within their relationships, many of the women indicated that they were experiencing their own mental health difficulties. This is not surprising given the wealth of literature that has indicated that partners of those with PTSD are affected by living with the condition in a range of ways, for example higher levels of stress, depression (Manguno-Mire et al., 2007), symptoms of PTSD, anxiety (Westerink & Giarratano, 1999), adjustment disorders, relationship dissatisfaction (Cook et al., 2004; Goff et al., 2007; Lambert et al., 2012), hostility and suicidal ideation (Manguno-Mire et al., 2007). Importantly, although the women tended to construct their own difficulties as being linked to their veteran partners', their

descriptions were more in line with general distress (such as anxiety, depression, hopelessness, stress and burn-out) rather than suggestive of PTSD or secondary traumatic stress (STS). This study therefore provided some additional insight into how partners of veterans may themselves be impacted by living with PTSD, and contributed further to the debate about whether distress is general or PTSD-consistent. Specifically, similarly to Renshaw et al.'s (2011) experimental exploration of the concept, the present study was more supportive of the more general definition of secondary traumatisation. However as with Renshaw et al.'s (2011) sample, a few of the participants in the present study reported some 'symptoms' which mirrored their partners' PTSD symptoms. In particular, there was a sense that the women had developed hyper-vigilance as a strategy to manage everyday family life. However, instead of being related to past traumatic events, they were increasingly sensitive to their veteran partners' moods and behaviours, contributing to their sense of *walking on eggshells*. Hyper-vigilance of this nature was also reported in Gerlock et al. (2014)'s qualitative investigation into couples living with combat-related PTSD, emphasising the value of qualitative research in gaining insight into the subtleties and the meaning given to 'symptoms'. It may be the case that quantitative studies into secondary traumatisation in partners which employ measures of hypervigilance falsely conceptualise this as being directly linked to the veterans' primary trauma, rather than as a more general consequence of living with the effects of trauma on a daily basis.

Similarly, two women in the present study had previously been subjected to domestic violence in their relationship with their veteran partner, reminding us that there may be primary traumas contributing to the dynamic in addition to secondary elements. Nelson and Wright (1996) also noted that not all trauma will be secondary and given the higher rate of domestic violence reported in some studies of relationships where the veteran has PTSD (Manguno-Mire et al., 2007), it is important that explanatory models of trauma in these

couples do not minimise the potential role of primary trauma. The present study therefore built on previous research by gaining a rich sense of how partners constructed the way in which they were affected by living with combat-related trauma, suggesting that it is more complex and multi-faceted than is often conceptualised within narrow conceptualisations of secondary traumatisation.

There was a sense, both within the family and military system, that emotional problems should not be discussed. This left some women blaming themselves for the family difficulties, thus maintaining their strategy of *walking on eggshells* and for there to be high levels of emotional expression within the family but without discussion and resolution afterwards. A lack of positive communication can have a detrimental impact on family functioning and has been found to link with a general sense of emotional numbing and avoidance (Evans et al., 2003; Galovski & Lyons, 2004). This veil of silence arguably may be partly linked to mental health stigma, as concern about public stigmatisation has been reported as a key barrier to seeking help in US and UK Armed Forces cohorts (Hoge et al., 2004; Iversen et al., 2011), as has internal stigma – that is, holding stigmatising beliefs about themselves as to how mental illness would impact them (Langston et al., 2010). Importantly, Langston et al. (2010) found that distressed personnel were more likely to hold these internalised stigma beliefs, meaning those who were in most need of support were less likely to seek it. Indeed, some veterans in the present study were said to relate to less than sympathetic historical views around combat-related distress, feeling themselves to be akin to those shot for cowardice during the First World War. The *hero* narrative, discussed in more detail later on (p.129), therefore potentially served some function in allowing veterans to defend against internal and external stigmatisation.

Not talking about difficulties and use of avoidance as an acceptable way to manage traumatic experiences has also been reported in other cohorts, such as older adults (Hiskey &

McPherson, 2013). These authors reflected on the apparent shared values within their focus groups of community dwelling older adults, such that there was agreement that it is best not to complain about adversity and that their peers may perceive them as ‘whingeing’ if they talked about difficulties or sought professional help. One contributing factor to these values was hypothesised to be the shared historical and cultural context, which included living through the Second World War, scepticism about mental health difficulties, and perhaps traditional British stoicism that encourages the approach of ‘keeping calm and carrying on’. Similarities can be drawn here to the present cohort of veterans and their families, whose experience of emotional expression and trauma was influenced by their social position within military culture, accompanying narratives of traditional views of masculinity, a shared understanding that military operations must remain secret, and where strength and heroic behaviour was favoured over self-disclosure and displays of vulnerability. This perhaps links back to the predominance of anger in the expression of PTSD within veteran populations, in that it is a culturally appropriate way of expressing psychological distress.

Additionally, the findings included a process whereby the women constructed their veteran partners’ difficulties as meaning that they were in some way sick or damaged, with the former being a more optimistic position that was suggestive of possible change and recovery. The women consequently regarded it as being their responsibility to care for and stand by their partners, although some had come to the conclusion that their husbands were revelling too much in the sick role that confirmation with psychiatric diagnosis provided. Summerfield (2001) highlighted that the psychiatric diagnosis of PTSD may serve a range of functions for some individuals, such as allowing financial compensation and allowing them to be seen as a victim rather than perpetrator of atrocities. This, and the present findings, demonstrated the complex nature of receiving a psychiatric diagnosis for the veteran and their

families, meaning that clinical interventions should provide scope to consider the systemic impact of this.

The participants engaged in an active process of meaning-making to try and make sense of their experiences. One event that provided the explanation that the women were desperately seeking was actually hearing about the traumatic combat experiences their veteran partners had endured. Hearing about a loved one being at risk of death or serious harm is one factor which has been hypothesised to be central to the process of secondary traumatisation (Figley, 1995), however for the women in the present study, knowing more about what their partners had been through had the opposite effect – it allowed them to have a more compassionate understanding and therefore decreased their distress. This is similar to that reported by Outram et al. (2009) who also noted the value of sharing war stories as providing the women with an explanation for the difficulties, which allowed them to reattribute blame away from themselves as being the cause of the conflict within their relationship. One aim of therapeutic intervention with veterans and their families may therefore involve facilitating the sharing of traumatic experiences in a way which is safe for all family members.

Participants were able to take part in the study both if they met their veteran partner whilst he was serving (or before he even joined the Forces for a couple of women) and also if they began their relationship when their partner was no longer serving. Those who had known their partner before he began to show symptoms of traumatisation were particularly likely to construct the veteran as being sick, as they had been aware of a time when he was by all accounts healthy and functioning well. In these cases, the concept of ambiguous loss (Boss, 1999) can help explain the women's sense of their partner being physically present but emotionally absent, an observation also reported in other qualitative studies of the experiences of veterans' partners (Frederikson et al., 1996; Dekel et al., 2005a; Outram et al.,

2009; Nir et al., 2013). Ambiguous loss refers to situations where an individual is missing in some sense but present in another, which means that a normal grieving process cannot occur. This is described as being traumatic in itself for those trying to make sense of the partial loss of a loved one, meaning that they are unable to achieve the certainty and resolution that people tend to seek in such situations. Boss (1999) also emphasised the relational context of ambiguous loss such that the person still being present in some sense means that other people do not offer sympathy or a listening ear in the same way they would with a more typical loss. It is almost as though there is not a social script for dealing with such occasions and the family is left feeling guilty that they are partly grieving a person that physically remains in front of them. Ambiguous loss has also been applied to other populations such as family members of people with dementia (Dupuis, 2002) and parents whose children receive a life limiting diagnosis (O'Brien, 2007). In all these situations, including living with PTSD, there appears to be a link with the associated uncertainty about change of role – for example grieving the loss of a typical husband-wife relationship and wondering whether they even still are a wife if they no longer feel they recognise their husband (Boss, 1999). This shift in roles has been documented in other qualitative studies of women living with veteran partners diagnosed with PTSD, with a number specifically mentioning that the women felt their relationship felt more in line with a mother-child dynamic (Maloney, 1988; Dekel et al., 2005a; Outram et al., 2009). It makes sense therefore for ambiguous loss to be considered clinically as part of the process whereby partners and families in general are impacted by living with combat-related PTSD, and in turn, the effect this may have on the veteran themselves to notice that people are acting differently towards them.

The shift in roles constructed by the women tended to mean that they held, in some sense, more power within the relationship and that it felt unequal in terms of role distribution and decision-making about family life. The women portrayed a situation where they felt like

they were doing everything, which has also been noted in previous research of veterans' partners in other countries, and has been referred to as the women over-functioning (Maloney, 1988; Lyons, 2001; Nir et al., 2013; Vagharseyyedin, 2014). Although constructed by the women as being necessary to be able to manage everyday life, other authors have reflected on the systemic impact of over-functioning, perhaps meaning that the veteran feels that he does not have a role in the family, hence reinforcing withdrawal and both partners' sense of an unequal balance within their relationship. In the current study, consistent over-functioning was also constructed as being linked to the women's sense that their own emotional and physical health was being negatively impacted, leading to high levels of burnout. A number of quantitative studies have explored caregiver burden and burnout in partners of veterans (Beckham et al., 1996; Dekel et al., 2005n; MacDonell et al., 2014). For example, Calhoun et al. (2002) reported that levels of caregiver burden and psychological distress were higher in partners of Vietnam War veterans who had been diagnosed with PTSD compared to partners of veterans without a PTSD diagnosis, and that this increased with severity of PTSD and occurrence of violence within the relationship. On the other hand, Dekel et al. (2005n) found that partners' distress was linked to their perceived levels of caregiver burden rather than the severity of the veterans' PTSD symptoms. These findings, in addition to the current research, suggested that caregiver burden and over-functioning should be considered as one mechanism whereby partners are affected by living with combat-related trauma.

For the couples who had children, the women constructed one of their multiple roles as being to protect their offspring from the negative effects of living with PTSD/trauma. Despite their efforts, some of them reflected on how their children displayed signs of distress which seemed to be linked to their fathers' difficulties. This observation, explained by family systems theory and the approach to combat-related trauma posited by Figley (1983, 1986),

reminds us that all individuals within a system are likely to be affected by trauma and cannot be considered in isolation. Similarly, a review by White, de Burgh, Fear, and Iversen (2011) suggested that children with a deployed parent may be more likely to exhibit behavioural problems, as were those who had a parent with psychiatric difficulties. It was also noted that having one healthy, supportive parent was a protective factor, buffering the children from other difficulties that may be going on in the home. The concerns of the women in the present study therefore were justified in that they felt they served an important role in shielding their children from being exposed to all elements of the family's struggles. Clinically, this provided a further rationale for ensuring that partners of veterans with PTSD are well-supported by services, as promoting their health and well-being in turn allows them to be more able to adequately meet the needs of any children within the family.

This chapter has so far discussed how the findings in the present study shared many similarities with those reported in other qualitative research into the experiences of partners of veterans with PTSD. This suggested that there were areas of commonality between the way in which female partners of UK military veterans constructed their experiences, with their counterparts in the USA, the Middle East, Australia and New Zealand. This is important to know as, as outlined in the introduction, there is a strong rationale for considering trauma within the particular socio-cultural context in which it is expressed (Young, 1995). This links to another area in which the present study provided a novel contribution: highlighting the social narratives about veterans, warfare and the military which the women made use of when constructing their own experiences of living with combat-related trauma in the UK. The theme named *heroes don't do the dishes* summarised this finding and suggested that the women were largely critical of the heroisation of veterans, as this portrayal of military men perhaps contributed to their husbands' difficulties in expressing vulnerability, getting involved in the mundane aspects of family life, and prevented them from being able to voice

that in reality, they felt anything but a hero. It seemed that some veterans had adopted the hero role in a defensive way, perhaps to minimise the extent to which they felt guilty or ambivalent about certain aspects of their military career. Arguably, the propagation of this narrative may also serve a psychologically defensive role for both the military and society in general. Perhaps the ceremony and celebration of veterans as heroes means that the general public do not have to consider the difficult truth that young men and women are carrying out an extremely demanding (and at times life threatening) role that many of us do not want to do? And perhaps the military are invested in a story that paints heroes as those who do not challenge authority or convey their distress? Either way, it may be important for clinicians working with ex- and current military families to be aware of dominant social narratives and how they may be affecting and maintaining the expression of difficulties within a particular family system. In this sense, the heroisation of veterans can be conceptualised as a potential maintaining factor of combat-related PTSD/trauma, to be considered alongside the more typical maintaining elements of internal and external avoidance and hyper-vigilance.

Some prior qualitative literature has referred to social and cultural narratives which influenced the participants' experience of living with veterans with PTSD. This included veterans being seen as perpetrators of unjustified violence during the unpopular Vietnam War (Frederikson et al., 1996; McCormack et al., 2010) and as being unfairly favoured by the State in Iran (Nir et al., 2013; Vagharseyyedin, 2014). Some participants acknowledged narratives about necessary self-sacrifice inherent in being a wife (Dekel et al., 2005a), particularly in relation to views that their husbands had fought in wars that were religiously necessary (Vagharseyyedin, 2014). However previous research tended to report that participants attributed society as having hostile views towards veterans, rather than glorified perceptions. This again suggested the importance of considering cultural context when researching combat-related trauma.

These differences between societies in terms of attitudes to warfare and veterans can in turn have an impact on how combat-related trauma is expressed and understood. Messages received via media portrayals, political and governmental broadcasts, charitable organisations and films can have an influence on how society feels towards veterans, and thus how veterans and their families themselves make sense of their situation (Wessely & Jones, 2004). These cultural influences may also be accountable for the development of PTSD/trauma, such that events on the battlefield alone are not the sole explanation for combat-related trauma. This is summed up by Wessely and Jones (2004, pp. 102-103) in their attempts to explain the high rates of psychiatric disturbance in veterans of the Vietnam War, suggesting that “locating the causes in the nature of the war fighting per se is the least convincing position” as they questioned whether “the explanations lie not in the jungle of Vietnam but in the nature of American society and its struggle to come to terms with a war which was lost”. The power of social constructs therefore are likely to operate on a number of levels: on a conscious level in terms of some types of stigma and the use of heroisation to raise money for military charities, but on a more subtle level in terms of their role in maintaining family difficulties and influence on how ‘symptoms’ of trauma are expressed.

In the UK, MacManus and Wessely (2013) also acknowledged the presence of a dominant discourse of veterans as heroes and reflected on its influence on mental health help-seeking behaviour in this population. They noted the disparity between the construct of veterans as strong, resilient and heroic and dominant discourses around mental health service users as being vulnerable, suffering and disempowered. This is likely to represent a significant leap in self-perception and is posited as one barrier preventing some veterans from seeking professional mental health support once responsibility for their care is transferred to the NHS. Indeed, in relation to the present findings, it may also have affected the type of intervention favoured by some veterans such that those which contained elements of military

culture (such as accommodation similar to barracks) were seen as being further removed from civilian psychiatric institutions. Some women in the study constructed this as maintaining heroisation rather than facilitating the veterans' reintegration back into family life and wider civilian society. Although it is difficult to balance the need to provide veterans with treatment that will appeal to them and in which they will be more likely to engage, this study suggested that there is scope to better prepare veterans for the practical and emotional demands of family life. This perhaps could be incorporated into existing treatment programmes, or services may wish to develop more family-focused treatment options in which partners and children can be more actively involved.

The final theme within the present study related to the women's construction of the transition to civilian life as being a struggle, meaning that leaving the Forces involved multiple losses for their veteran partners which exacerbated their PTSD/trauma. This included loss of role, of status, of friendships, and the sense of family that military service had provided them. Other authors have also alluded to the huge adjustment that transition can demand on the whole family, which often means a reconfiguration of roles (Figley, 1993; Nelson & Wright, 1996; Deahl et al., 2011). In the current study, the military and senior personnel were constructed as representing attachment figures for some of the men, providing the containment, security and boundaries that the women perceived their partners had not received enough of during childhood.

Importantly, this links to an expanding area within the research literature that has indicated that a range of factors can increase an individual's risk of developing PTSD, including frontline combat exposure, being of lower rank, low team moral and poor social support, and appraising one's life as being at risk (Iversen et al., 2008). However, other predisposing factors also increased the risk for developing PTSD, which predated the individual's combat experience. These included experience of childhood adversity, low

educational achievement (Iversen et al., 2008; Jones et al., 2013a) or experiencing a serious accident, meaning that some individuals are more vulnerable before they even enlist in the Forces. Others have found that pre-enlistment antisocial behaviour predicted later behavioural difficulties (e.g. alcohol abuse, anger and aggressive outbursts) in a cohort of UK Iraq War veterans (MacManus et al., 2012).

The question of who becomes traumatised is one that has been explored in a range of populations. The existence of childhood trauma and adversity is well-documented as one vulnerability factor, interestingly, particularly so for military samples (Brewin, Andrews, & Valentine, 2000). One explanation for this is that military samples are more likely to include individuals with chronic PTSD, and childhood adversity and low education status are better predictors in the case of chronicity (Brewin et al., 2000). Therefore the historic notion discussed in the introduction chapter- that the original construction of the diagnosis of PTSD encouraged society to adopt the notion that anyone could develop psychiatric problems following a traumatic event, is now regarded as being too simplistic- as is the alternative narrative that people with mental illness are biologically or genetically different. A more adequate explanation lies between the two positions: that we are aware of the devastating effects that experiencing a traumatic event can have on many people, but that those with certain characteristics or prior exposure to traumatic events are more vulnerable to developing longer term difficulties (Wessely & Jones, 2004). Indeed, the effect of experiencing multiple traumas in childhood has been said to have a cumulative effect, leading to increased symptom complexity in adulthood (Briere, Kaltman, & Green, 2008).

However, awareness of individual risk factors should not detract us from considering the influence of social deprivation and the link with mental health difficulties, specifically that mental ill health has been repeatedly found to correlate with poverty (Murali & Oyeboode, 2004). This observation is perhaps more pertinent given that the majority of new recruits are

young people from less advantaged socio-economic backgrounds (Walker, 2010). The recruitment of young men to the Forces when they are still in adolescence has also been criticised due to concerns that it may be detrimental to the psychosocial development that needs to take place at this age for a healthy sense of self (Maloney, 1988). The same could be said for neurological development. Adolescence is a key stage for the growth and ‘pruning’ of neurons, which is affected by the environmental conditions and demands in which the young person is living, meaning that stress can have a long-term impact on the developing brain. Thus, in these times of austerity, we need to remain critically aware that some young people living in areas of higher social deprivation may feel that they have limited options for their careers, which could unduly influence their choice about joining the military. That said, there are many reported benefits to a military career and it is difficult to predict beforehand who may struggle to cope with the demands of it (Rona et al., 2006), making it even more important that adequate support is providing for veterans and their families following their transition to Civvy Street.

In reference to the current study, although not directly asked, many of the women mentioned their own trauma histories – including experience of domestic violence, loss of a child, difficult relationships with own parents – meaning that these may influence their experiences and constructions of living with the secondary effects of combat-related trauma in their present day lives. This links back to the Couple Adaptation to Traumatic Stress (CATS) model (Goff & Smith, 2005) which indicated that the expression of trauma within a dyad is influenced by each person’s individual level of functioning, their predisposing factors (e.g. trauma history) and resources, and couple functioning. The women in the present study referred to each of these elements, for both themselves and their veteran partners, when constructing their understanding of how combat-related trauma influenced them and their relationships. In terms of clinical intervention, assessment could focus on gaining insight into

these multiple factors and current relational functioning, to help ascertain the most effective approach to intervention.

4.3. Summary of Implications for the Concept and Process of Secondary

Traumatisation

Adopting a more general, inclusive definition of secondary traumatisation by default means that the process whereby partners become impacted will also be broader and multifaceted. The women in the present study were most likely to construct their experiences as being more in line with a broad definition, such that they alluded to general feelings of burnout, anxiety, and depression rather than symptoms that were consistent with PTSD. They therefore also constructed the process of how they were impacted as consisting of many elements, including: caregiver burden, contributed to by over-functioning within the family and the everyday demands of living with someone who is struggling; needing to *walk on eggshells* and subdue their own emotional needs; dealing with grief and ambiguous loss; and feeling pressurised to continue in their caring role and feeling isolated because of dominant social narratives about veterans as heroes. Instead of feeling traumatised by stories of warfare and concerns about what was happening to their loved ones – the mechanism proposed by Maloney (1988) - they instead felt more able to empathise and less distressed through hearing about the traumatic events. It seemed that the women's experiences were therefore more consistent with Gilbert (1997)'s proximal STS definition, where spouses are adversely affected by day to day life with a traumatised individual, than distal STS which posited that secondary traumatisation occurs due to concerns about what a loved one is going through. In terms of the present study, the fact that around half of the women were not in a relationship with their partner whilst he was deployed is likely to mean that distal STS would not be a potential mechanism, as is the observation that many of the women did not hear any trauma stories until later down the line when they knew their partner was physically safe.

Presumably this would mean that there would not be the necessary level of emotion (e.g. extreme fear and shock) to lead the memory to be stored in the amygdala (see the introduction chapter for explanation of how trauma memories are encoded), therefore it being unlikely to result in classic PTSD symptoms (flashbacks etc.). This means that other cohorts of partners of veterans or currently serving personnel may indeed experience PTSD-consistent presentations if their situation differs from the participants of the present study, and therefore the findings are not intended to generalise to these other groups.

4.4. Implications of the Study

4.4.1 Clinical implications. Some of the clinical implications of the study's findings have been highlighted throughout this chapter. The key message from the present research was the importance of considering the veteran as being part of a relational and cultural system, rather than just as an individual. This not only means that partners and children of veterans should receive more support to benefit their own well-being, but that it would also in turn promote the mental health of the veteran. This is particularly pertinent as there is some evidence that veterans have indicated that their treatment priorities concerned support with relationships with partners and parenting children (Khaylis et al., 2011). Additionally, increased levels of PTSD in UK reservists compared to regulars has been found to be linked to perceived family difficulties rather than events in Iraq (Browne et al., 2007), and given that there are current moves to increase the number of reservist forces, this provides an additional rationale for broadening the approach from individual-focused to family-focused work. Reintegration into wider society and to the family is such an important task, and given that support with this tends to lie with veterans' partners (Gerlock et al., 2014), it makes practical and clinical sense to invest more in building the resilience of partners and other family members.

This might involve providing additional support directly for partners, or including them in some of that which is aimed towards veterans. As mentioned throughout this section, areas for consideration within therapeutic intervention might include: the meaning and impact of anger; helping couples re-evaluate the distribution of roles and the impact of over-functioning and under-functioning on their relationship and sense of belonging/reintegration into a family; encouraging partners to prioritise self-care and having an outlet for them to express their own struggles; where clinically appropriate, supporting the safe telling of war trauma stories to aid understanding between the couple; and to ensure that the needs of any children in the family are held in mind. The CATS model could act as a useful framework for both assessment and intervention, as the current study supported the idea that individual functioning and predisposing factors of both parties (including previous trauma history), in addition to couple functioning, affected and was affected by the impact of combat-related trauma within relationships.

This study also highlighted the importance of considering the role of dominant social narratives about veterans and warfare on how families make sense of their difficulties. This included their role in potentially maintaining PTSD/trauma symptoms, such as through the heroisation of veterans. One way to address this with families could be through employing a social constructionist approach to systemic family therapy, which considers the influence of social narratives on the way in which families make meaning (Dallos & Urry, 1999). This approach posits that families reproduce - rather than create - oppressions and dynamics that exist in wider society (Dallos & Urry, 1999). By drawing attention to these influences, the therapist can help a family strengthen subjugated narratives about themselves and their situation which may previously been difficult to access.

4.4.2. Directions for future research. The present study suggested that there is scope for future research to explore how partners of different ages make sense of their experiences

of living with combat-related trauma. Some of the older women who participated spoke about a sense of regret and that time had run out for them to be able to expect anything better in their marriages, and that it was too late to start again. It would therefore be interesting to have a better understanding of how trauma is negotiated in relationships across the lifespan, allowing us to provide better age-appropriate services for veteran couples.

During the process of recruiting for this research, mothers, fathers, children, siblings, and ex-wives of veterans with PTSD contacted the researcher to express interest in participating, but were unable to do so due to not meeting the inclusion criteria. The level of interest however highlighted that all individuals close to a veteran with PTSD are impacted, and wished to tell their stories to help others in their situation. There is little published qualitative research into the experiences of these family members, meaning important contributions to the knowledge base could be made by exploring these areas.

The current study did not consider the impact of physical injuries on the emotional health of the veteran and their family. Again, during the recruitment stages of this research, family members of veterans (who did not meet inclusion criteria for this study) spoke about how traumatic it had been for them to care for a loved one who was in a coma due to physical combat-related injuries. Although their veteran family member had recovered with no lasting effects, they themselves had continued to experience mental health difficulties and symptoms of trauma as a result, long after health care professionals had retreated from a seemingly successful outcome. This highlighted that there are numerous processes which families of veterans potentially experience, involving actual loss, ambiguous loss, shifts in roles and significant periods of transition. Qualitative research can help us gain some insight into some of this complexity and allow services to better support families who find themselves in these situations.

4.4.3. Wider implications. The findings of this study may suggest that other groups of individuals suffering from the negative impacts of trauma (e.g. survivors of childhood sexual abuse or rape) could benefit from having their partner and/or other close family members involved in therapeutic intervention, although further research with different populations is required to explore this. It should be noted that some families of veterans are coping with additional stressors other than living with trauma that are unique to their situation, including the experience of transition from military to civilian life, with other groups of clients are unlikely to be undertaking. However in their qualitative interview study of 17 couples where one or both individuals was a trauma survivor, Henry et al. (2011) found that there were some common problematic relational processes that occurred within the dyad, no matter what the trauma (e.g. including themes relating to lack of intimacy, change or intensification of roles). Additionally, it has already been posited that couple therapy is a valuable and appropriate approach to therapeutic intervention where one member of a dyad is experiencing PTSD (Johnson & Williams-Keeler, 1998). Johnson and Williams-Keeler (1998) discussed how the marital relationship has the potential to foster resiliency in each member and provide a corrective emotional experience for the traumatised individual. On the other hand, they noted that the symptoms of trauma can have an extremely detrimental impact on even the most stable relationships, which without intervention could fail, leading to worsening in the wellbeing of both partners. Therefore, although the results from this study may not generalise to all trauma client groups, there may be scope for clinicians to hold in mind that the most appropriate point of their intervention may be that which is directed at the couple relationship, but additional research is required to explore this further.

4.5. Critique of Methodology/Strengths and Limitations

The present study contributed to the literature base on how female partners of UK military veterans are affected by living with combat-related trauma, utilising a methodology

that allowed these women's voices and stories to be heard in an in-depth and rich way. The sample size was adequate in comparison to other qualitative studies in this area, and applied a social constructionist epistemological framework which does not appear to have been used previously. The women felt able to disclose and speak freely about their situation, which was supported by the researcher giving a choice as to the location and method of interview.

However, the study also had some limitations. From the outset, the approach to recruitment hoped to access a diverse sample of partners, including men and people in non-heterosexual relationships, but this was not achieved. It may however have been an unrealistic target, given that the proportion of women in the Forces stands at only 9.9% (as of April 2014) (Ministry of Defence, 2014), and although at the time of writing, the MOD no longer collected data on sexual orientation estimates from the UK general population suggest that less than two percent of people self-identified as being homosexual or bisexual (Office of National Statistics, 2014). Nonetheless, this limited the transferability of findings to other types of relationship. It would have also been preferable to have recruited some partners who fell in the upper and lower age ranges (e.g. lower than 26 and older than 69 years old), as older adults in particular have tended to be under-represented in research participation (Mody et al., 2008).

Also affecting transferability of the findings was that the sample of veterans, as a whole, consisted of individuals who presented with complex difficulties which for some had persisted for decades. Although formal quantitative data was not collected in relation to complexity or severity of mental health difficulties, the descriptions from the female participants suggested that their veteran partners were struggling greatly with everyday life and relationships and required a large degree of support, and that for those who had received treatment, this had so far had limited effectiveness. As mentioned above (p.133), some veterans were described as having experienced multiple traumas including some in

childhood, which added to the complexity of their presentations. This therefore suggested that the results from this study do not necessarily transfer to families of veterans with milder presentations of PTSD, those who respond well to brief psychological intervention or other treatment approaches, and those who experience initial problematic responses to trauma but who recover fairly rapidly with social support and a period of respite. In relation to this, a possible limitation of this study was that quantitative data on PTSD severity, complexity and chronicity was not collected, which therefore prevented the data from different participants to be fully compared and contrasted along these factors.

One exclusion criteria was that the couple needed to be in a current relationship, meaning that they were a subset of individuals who remained committed and arguably had certain characteristics that meant they were able to cope with the challenges associated with their situation. These women were perhaps in the minority, and it would be useful to understand why some partners decide to stay and others leave their relationships with veterans who have a diagnosis of PTSD. This is likely to be a complex process, but it means that the current findings may not translate well to situations where there is relationship breakdown.

As outlined in the method section of this thesis (p.65), the decision was made during the recruitment period that it was necessary, in the interests of recruiting a sufficient number of participants, to omit the inclusion criterion that partners were required to have been in a relationship with their veteran partner whilst they were still serving in the military and before the point of traumatisation. Although only two participants were interviewed before this criterion was changed, in the end the majority of participants (60%) would have actually met this criterion. In an ideal world, it may have been better for consistency's sake, to have remained with the original criterion for longer and seen how the recruitment progressed over time. Although this methodological choice was kept in mind during the analysis, the process

and dynamics involved in selecting a romantic partner are hugely complex and multifaceted. It therefore, was still a limitation to the research that the choice was made to include both people who knew that their partner was struggling with emotional distress at the start of their relationship and people whose veteran partner developed difficulties later on.

Thematic analysis is a flexible and relatively straight-forward approach to qualitative analysis, which enabled the study's research questions to be addressed. Applying a social constructionist lens allowed for the impact of wider social narratives to be explored, meaning that there was some crossover with thematic approaches to discourse analysis. However, thematic analysis does not allow for detailed examination of the use of speech which was data that was therefore excluded from the analysis. On reflection, the researcher may have wished to conduct the research using discourse analysis as the chosen methodology, as many interesting uses of language emerged. Alluded to briefly in the results section of this report, many of the women used military language when talking about their situation (about it being a battle, a fight, and being caught in the crossfire etc.) and also stuttered, hesitated, and became momentarily incoherent when discussing particular difficulties. The minutia and structure of speech however could not be explored within this methodology, but future research may wish to adopt discourse analysis as a potential approach to exploring this area.

Additionally, the present research focused only on interviewing partners, to the exclusion of veterans themselves. Given the relational focus of the study, one option could have been to recruit couple dyads to participate, to allow some of the dynamic of the relationship and different views to be accessed. However, as the study was carried out from a social constructionist epistemological position, it was not concerned about accessing one true reality about the couples' relationships, but appreciated that there are multiple, constantly changing truths which were co-constructed with the researcher. Future research though may wish to focus on the couple relationship by involving both members in the research process.

Finally, this research adopted a stance which was critical towards diagnostic labelling for the reasons outlined in the introduction and method sections. However, it proved difficult to talk or design recruitment materials that the general public would understand, without using *PTSD* as a shorthand. It nevertheless tended to be the participants' choice of language anyway, rather than them adopting the more general term of *trauma* (which in itself remains a psychological label, although arguably less restrictive than a diagnostic category). The use of psychiatric labels also has its utility in research, such that it can allow studies to be identified and compared as being interested in a similar phenomenological experience (i.e. allowing a meta-analysis or meta-synthesis to be carried out). This issue remains a complex one for clinical psychology, given the pressures and advantages of adopting such diagnostic terms, but at the same time recognising the profession's role in challenging such categorisation of human distress (Division of Clinical Psychology, 2013).

4.6. Self-Reflexive Statement

As mentioned in the methodology section of this thesis (p.76), self-reflexivity is central to the process of conducting qualitative research, such that the researcher should consider how their views, social position and experience may have influenced the research process. Instead of being a limitation, these elements are seen as contributing to the co-construction of the research as long as they are acknowledged and in keeping with the study's epistemological standing. I believe that my position as a female, and politically identifying as a feminist, will have influenced the collection and interpretation of the data. I was aware of some moments in the interviews where I was pulled into seeing elements of the difficulties as being 'male problems', and feeling strongly loyal to the female participant and vilifying of the male veterans, whose voices I was unable to hear. I had to remind myself that I was only hearing one side of the story, and in line with social constructionism, was not accessing the real truth about their relationships. My identification with them though may have contributed

to the sense that it was a safe place to talk and that I was able to empathise with their struggles.

Related to this, may have been my tendency at first to focus more on the negative elements of their stories and the difficulties they faced, at the expense of any resilience factors or strengths in their relationships. This was likely to have come from my identification with their struggles, but also it being more in line with my clinical interests and thus appearing to me a more appropriate way to answering the research questions. However, my reflective journal allowed me to notice this pattern early on, and to compensate, I purposely altered my attention towards noticing positive/strengths-based elements when coding the interviews. This is a strategy recommended by Braun and Clarke (2013).

I also reflected on how I was impacted by some of the practicalities underlying the research, and whether there was any influence on the data as a result. Most individuals chose to be interviewed in their own homes, whereas others requested to be interviewed in an outside location of their choosing (e.g. in a café), and one person was interviewed over the telephone. Although I did not feel that the differences in location caused much variation in terms of what the participants felt able to disclose (as they had purposely chosen a venue in which they would feel more comfortable), I noticed in myself that I was aware of particular elements of the environment depending on where we were. For example, one participant chose to be interviewed at home but purposely (it seemed to me) left open the door to the room in which we were sitting. When I asked where her husband was, she said that he was upstairs in the house. I did not ask about this at the time, but I remember feeling again that the process of taking part in this study fulfilled a particular function for some individuals (i.e. an indirect communication to their veteran partner about the level of distress they themselves were experiencing), aside from the obvious of wanting to participate in a research study and tell their story. I had a sense of being caught in a dance with the couple dynamic in some

way, and felt very much that that the partner's participation in the research was part of them negotiating the stages of their joint journey in making things better for themselves.

Additionally, there were other occasions when I was aware of the veteran partner being in the house at the same time and wondering how much of the story being shared with me was one that had already been aired between the couple, and what the veterans' responses might be if they overheard some of the dialogue. With those interviewed outside of the home, I was more aware of the potential of a bystander overhearing and the possible breaches of confidentiality, and for the woman interviewed over the telephone, I was aware that I could not gauge so well her level of distress or emotional response to my questions, being unable to read her facial expressions and other non-verbal cues. These factors all affected in different ways my emotional responses and thought processes during the interviews, which in turn were likely to affect my behaviour and approach to asking questions – I think mostly in subtle ways.

One other notable characteristic that I held in relation to the participants was my role as a trainee clinical psychologist. It became apparent throughout the data collection stage of the research that many of the women had volunteered to take part as they had wanted someone to talk to, as this was not forthcoming in other areas of their lives (either from their own families or professionals). Indeed, a couple of the women told me that they had not spoken to anyone before about their family's situation and were using the research as a way to practice talking about it, which they saw as a step on their journey to gaining more help for themselves and their husbands. One participant told me that her husband had never spent time alone caring for their son, but because she was taking part in the research, he had taken their son out for a day trip - thus my entry into the family system had wider implications than just conducting an interview. These examples led me to reflect that there is less of a clear boundary between the therapeutic and research elements of being a clinical psychologist than I originally thought. This also has ethical implications for this type of research, highlighting

to me that people have different motivations for participating in studies. In the case of the present study, this included some women meeting an emotional need through a means that was potentially not the most appropriate avenue. The women also spoke freely for significant lengths of time and, for some at least, there was a sense that it was a relief to vent about their pent up difficulties. I felt that these were important findings in themselves, reinforcing the women's viewpoints that professional health was not forthcoming, but it also meant that I felt emotionally affected by hearing their stories. This emotional experience though has been important in maintaining my passion to ensure that this research is disseminated and that I will continue to seek out opportunities to either research and/or work clinically to improve support for this group of people in the future.

4.7. Conclusion

This study contributed to the body of research by addressing a gap in our knowledge about the constructed experiences of partners of UK combat veterans living with PTSD/trauma. A number of clinical implications were identified as a result of these findings, which in summary, suggested that practitioners working with UK combat veterans should consider giving attention to assessment of the couple relationship and be open to the role that this may play in the maintenance (and therefore resolution) of difficulties. This would, of course, be in addition to the benefit from improving the wellbeing of partners and families in their own right. This thesis also identified areas for future research, which ideally should be specific to the UK Armed Forces, rather than attempting to generalise from other nations.

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Appendix A

DSM-5 PTSD Diagnostic Criteria (American Psychiatric Association, 2013)

- **Criterion A: stressor**

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

- Direct exposure.
- Witnessing, in person.
- Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
- Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

- **Criterion B: intrusion symptoms**

The traumatic event is persistently re-experienced in the following way(s): (one required)

- Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
- Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
- Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may re-enact the event in play.

- Intense or prolonged distress after exposure to traumatic reminders.
- Marked physiologic reactivity after exposure to trauma-related stimuli.
- **Criterion C: avoidance**

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

- Trauma-related thoughts or feelings.
- Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).
- **Criterion D: negative alterations in cognitions and mood**

Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

- Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
- Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
- Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
- Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
- Markedly diminished interest in (pre-traumatic) significant activities.
- Feeling alienated from others (e.g., detachment or estrangement).
- Constricted affect: persistent inability to experience positive emotions.

- **Criterion E: alterations in arousal and reactivity**

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

- Irritable or aggressive behaviour
- Self-destructive or reckless behaviour
- Hypervigilance
- Exaggerated startle response
- Problems in concentration
- Sleep disturbance

- **Criterion F: duration**

Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

- **Criterion G: functional significance**

Significant symptom-related distress or functional impairment (e.g., social, occupational).

- **Criterion H: exclusion**

Disturbance is not due to medication, substance use, or other illness.

Specify if: With dissociative symptoms.

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).

Derealisation: experience of unreality, distance, or distortion (e.g., "things are not real").

Specify if: With delayed expression.

Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

DSM-IV-TR PTSD diagnostic criteria (APA, 2000)

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

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

2. The traumatic event is persistently reexperienced in one (or more) of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

- Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience; illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

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

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall an important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feeling of detachment or estrangement from others
- Restricted range of affect (e.g., unable to have loving feelings)
- Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal lifespan)

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

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating

- Hypervigilance
- Exaggerated startle response

5. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

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

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

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

Appendix B

Recruitment advert

Researching the impact of combat-related trauma on partners of veterans

Is your veteran partner experiencing symptoms of trauma/PTSD?

**Do you want to help us improve support for veterans and their
families?**

My name is Emily Doncaster and I am a Trainee Clinical Psychologist from the University of Essex. I am carrying out a research study into civilian partners' experiences of being in a relationship with a veteran who has symptoms of trauma (which may also be known as posttraumatic stress disorder or PTSD).

I am interested in your views about how living with trauma affects you and your family, particularly your relationship with your partner. The aim of the research is to help us find ways to improve the support and treatment that is offered to veterans and their families.

If you are interested in participating in this study, please contact me on **Tel: 07527634317** or **Email: edonca@essex.ac.uk** for more information. I can offer a £10 high street voucher as a "thank you" for your time and a summary of the research findings once the study is completed.

Appendix C

Interview topic guide

Thank you very much for agreeing to take part in this interview. Just to remind you, it should take around 1.5 hours, but if you want to stop or take a break we can do so. If you do not want to answer a question, or decide you no longer want to take part in this study, you can let me know – and your data does not need to be included in the write-up. Also, as mentioned before, any details that could identify you will be changed (e.g. I will give you a different name), and what we discuss is confidential unless, as I mentioned before, you say something that leads me to think that you or someone else may be at risk of significant harm. On those occasions, I may need to pass on information to a third party to make sure you are safe.

I have some questions here to guide us, but it is fairly open to allow us to discuss issues that are relevant to you and your situation. As you know, I am interested in your own experience of living with a veteran who is showing symptoms of trauma following their combat experience. Therefore, it would be great if you could tell me about how you personally are affected, your views on how your partner is affected, and the impact on your relationship and wider family. Does that sound OK? Do you have any questions before we start?

- **Expectations of your partner's most recent homecoming OR early expectations of relationship**
- **Concerns for your partner**
 - First realising there was a problem
 - Signs something was wrong, what did you notice (prompt for example)
- **Impact on you**
 - How it has impacted
 - Why it has impacted you (process)
 - How this in turn impacts on your partner (if at all)
 - Perception of veteran/warfare/country and any changes to this
- **Impact of trauma/PTSD on your relationship**
 - Negative aspects (prompt for example)
 - Positive aspects? (prompt for example)
 - Any changes in impact over time
 - Why it has impacted relationship (process)
- **Impact on family**
 - Who is affected? (Wider family?)
 - Impact on children
 - Their perceptions of veterans/warfare/country and any changes to this
 - Perceptions of how their situation is viewed by UK society

Is there anything else you would like to mention?

Appendix D

Participant information sheet

Participant Information Sheet**What is the research study about?**

My name is Emily Doncaster and I am a Trainee Clinical Psychologist from the University of Essex who is carrying out a research study into the experiences of partners of UK veterans. I want to speak to people who are in a relationship with a military veteran, where the veteran is showing signs of psychological trauma as a result of their service experiences. These difficulties may have been diagnosed as post-traumatic stress disorder (PTSD) by a professional. However, your partner does not need to have been diagnosed for you to take part in this study. It may be that you think that your partner is struggling, but they have not been diagnosed or received professional help yet.

Up until now, lots of research has focused on what living with trauma is like for the veteran themselves, but we know less about what the experience is like for partners and other family members. It is important for us to know more about this, as partners and the wider family can also be affected by trauma. This means they may need support themselves, but also that they can play a key role in helping the veteran to get better. I hope that this study will provide information that will allow us to improve support for families and psychological treatments for veterans and their partners.

Who can take part in the study?

You are able to take part in the study if you meet all of the following criteria:

- Are 18 or over and are currently (i.e. not separated or widowed) in a relationship with a UK veteran, and have been for at least two years. You can take part in the study if you are currently living apart from your partner, but still see yourselves as being in a relationship.
- Your partner is no longer a member of the Armed Forces or the Reserve Forces.
- Think that your partner has PTSD and/or signs of trauma as a result of their military experience.
- Are not a member of the Armed Forces (either currently or previously serving) yourself.
- Live in London, the South East or East of England.

I am interested in interviewing both male and female partners in opposite- or same-sex relationships. The interviews will be around 1.5 hours long and can take place at your home or another quiet and private place that we can sort out in advance.

What are the benefits of taking part?

This is a chance to help us improve our knowledge about the experiences of veterans' partners, which means we can have a better understanding of how trauma may impact other people who are close to the veteran. I plan to publish the findings from this research in academic journals and to share it with organisations who work with veterans and their families. This means that the information you provide could help the way we think about supporting people in the future.

What are the potential risks of taking part?

I am interested in hearing about how your partner's PTSD/trauma has affected you and your relationship. Therefore, I will not be asking you about your partner's traumatic events directly. However, it may be the case that when talking about these issues you become upset. If this happens, we can take a break and you will be able to end the interview if you wish. If you feel that you would like to get some help for the way you are feeling, I will be able to give you a letter to take to your GP to suggest that they discuss options with you. I will also provide you with a list of contact details for support organisations and helplines.

However, partners of veterans who have taken part in similar studies in other countries said that they found it rewarding to talk about their experiences. Some people also said it was satisfying to be able to share their stories to help others.

Is it confidential?

Your name, location and any other identifiable information will not be included when I write up the study. The interviews will be transcribed verbatim and anonymised, and you will be given a different name (also known as a "pseudonym") when I type up the interviews. I will need to record the interview, but this will be encrypted, stored on a password-protected computer and deleted once the project is completed. The transcriptions will also be encrypted, password protected, saved on a password-protected computer and deleted once the project is completed. Only I will have access to any personal data. My supervisor will have access to anonymised audio files and transcription files in order to check for accuracy. Extracts from your interview will be included in the write-up of my research, but these will be anonymised.

The only time that I would have to break our confidentiality is if I thought that you or another member of your family were at serious risk of harm (either to yourself or from others). I also would have to break confidentiality if I thought you were at risk of harming another person, or if a child was at significant risk of abuse or neglect. If there were

signs that this was the case, I would need to pass on information to ensure the safety of you or another person, but wherever possible I would discuss this with you first.

What if I change my mind about taking part?

If I ask a question that you do not wish to answer, this is completely fine. You are free to stop the interview at any time, and you can ask for your data to be removed from the study. Whether you decide to take part in the study or not, this will not affect the care or support you receive from the NHS or any other organisation.

Will I hear about the findings of the research?

I can send you a summary of the findings of the research, once it is completed. There is a space on the consent form to indicate whether or not you are interested in receiving this.

Will I be paid for taking part?

I am unable to pay people for taking part, but I am able to offer interviewees a £10 high street voucher as a “thank you” for your time and participation.

What if there is a problem?

You can contact me at any time during the duration of the research study (which will be up until September 2015) using the details below. If I do not answer the telephone, please feel free to leave me a voicemail message and I will aim to get back to you within 24 hours. If you have a complaint or concern and want to speak to someone other than me (or if you wish to speak to someone after September 2015), you can contact my research supervisor Dr Leanne Andrews at the University of Essex. Leanne’s contact details are provided below.

Any questions? If you would like to take part in this study, or have any questions before you make up your mind, please contact me, Emily Doncaster, on the following details:

Researcher:

Emily Doncaster
Trainee Clinical Psychologist
University of Essex
Tel: 07527 634317
Email: edonca@essex.ac.uk

Project Supervisor:

Dr Leanne Andrews
Research Tutor for the Doctorate in Clinical Psychology
University of Essex
Tel: 01206 873910
Email: landre@essex.ac.uk

Appendix E

Consent form

Title of the Project: Living with combat-related trauma: Experiences of partners of UK veterans

Name of the Researcher: Emily Doncaster

- I confirm that I have read and understand the information sheet dated _____ for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. *Please write your initials in the box if you agree* ☐
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my medical care or legal rights being affected. *Please write your initials in the box if you agree* ☐
- I understand that I can remove my data from the study (up until the point the study has been written up) by contacting the researcher. *Please write your initials in the box if you agree* ☐
- I agree to the interview being audio-recorded and I understand that it will be stored securely and erased once the study is completed. *Please write your initials in the box if you agree* ☐
- I agree to the interview being transcribed and I understand that it will be anonymised, stored securely and deleted once the study is completed. *Please write your initials in the box if you agree* ☐

- I understand that my responses will be included in a written thesis and may be included in research papers submitted to academic journals and/or conference presentations, but that I will not be identifiable from this data. *Please write your initials in the box if you agree* ☐
- I understand that if there are indications that I or anyone else I mention (e.g. a child or my partner) are at serious risk of harm, the researcher will need to pass on information about me to another organisation (e.g. GP, social care, police). However, she will discuss this with me first wherever possible. *Please write your initials in the box if you agree* ☐
- I **would/would not** (delete as appropriate) like to be sent some information on the findings of the research study once it is completed.
- I, _____ agree to take part in the above study

Participant

Signed _____

Print Name _____ Date _____

Researcher

Signed _____

Print Name _____ Date _____

Appendix F

List of helplines and support services

Helplines and support services

Combat Stress 24-Hour Helpline is for the military community and their families and offers advice on various issues such as mental health and practical support. The helpline can be reached on **0800 138 1619**. You can also text on **07537 404 719** (standard charges apply for texts) or email **combat.stress@rethink.org**.

Mental health

Samaritans offer support 24-hours a day. Contact them on **08457909090** or **jo@samaritans.org**.

Mind provide a helpline for information about mental health which is available Monday to Friday, 9am-6pm on **0300 123 3393** or email **info@mind.org.uk**.

Domestic violence

For women:

24-hour National Domestic Violence Freephone Helpline is accessed on **0808 2000 247**. The Helpline is staffed 24 hours a day by fully trained female helpline support workers and volunteers.

For men:

Men's Advice Line is a confidential helpline on **0808 801 0327** for any man experiencing domestic violence and abuse from a partner (or ex-partner) and is available Monday-Friday, 9am-5pm. Alternatively, email **info@mensadviceline.org.uk** (aim to reply within two working days).

ManKind Initiative provides a national helpline on **01823 334244** to offer support for male victims of domestic abuse/violence. Monday to Friday 10am - 4pm and 7pm - 9pm.

Male or female perpetrators of domestic violence:

The Respect Phonenumber is available on 0808 802 4040 and is open on Monday – Friday, 9am-5pm.

Rape and sexual violence

For women:

Rape Crisis England and Wales (women only) offer a freephone helpline on **0808 802 9999** between the hours of 12 - 2.30pm and 7 - 9.30pm.

For men:

Survivors UK provide a dedicated helpline available on **0845 122 1201** for men who have experienced childhood sexual abuse or adult sexual assault / rape, and their partners and carers. It is available on Mondays and Tuesdays between 7pm and 9.30pm or Thursdays between 12pm and 2:30pm.

Addictions

Alcoholics Anonymous are available on **0845 769 7555** or email help@alcoholics-anonymous.org.uk.

Narcotics Anonymous are available on **0300 999 1212**.

Adfam provide support and information for families affected by drug and alcohol addiction. See their website at <http://www.adfam.org.uk/>.

Relationships

Relate provide relationship counselling services. Find out more at www.relate.org or call **0300 100 1234**.

Appendix G

Demographic questionnaire

About you**Age:****Sex:****Ethnicity:****Do you have any children who live with you? If yes, please list ages.****About your partner****Age:****Sex:****Ethnicity:****Most recent rank in Armed Forces:****Which conflicts did they serve in?****How long did they serve:****How long ago did they leave the Forces?****Have they been formally diagnosed with a mental health condition? If so, please note this down.****About your relationship****How long have you been together?****Do you live together?****How would you describe the status of your relationship (e.g. married, civil partnership, cohabiting)?****Were you together when your partner was deployed?**

Appendix H

Excerpt from interview transcript ('Georgia')

1 Interviewer: ...as you know I'm interested in your experiences of being a partner of a veteran with
2 PTSD... To start us off I wonder if you could tell me a bit about how you and your husband met, and
3 your early expectations of your relationship?

4

5 Georgia: We knew each other when we were teenagers. Erm my husband was at that time in the
6 Navy and I used to socialise quite a bit in a pub, believe it or not, and he used to visit the same pub
7 when he was on leave so that's where we secured a friendship as such. Erm we re-met I suppose
8 about nine years ago, after a bit space in our lives. Erm his marriage he was in, of nineteen years,
9 was failing. He came out of that marriage and came to live with me. At the time, I was a single
10 parent, and I think this is quite a poignant fact, I had been a single parent of three children for (..) my
11 daughter's twelve and a half now so take off eight years, she would have been four and a half. Um
12 I'd been a single parent for about eight nine years, having then had another baby and being alone
13 with them. And I think I saw my husband as a release from the toils of single parentism, cos nothings
14 easy when you're a single parent. And he was, because his marriage was failing, he was more than
15 happy to move on with his life and coming into what I would call the folds of my house. I have my
16 own house um, children were there, we were comfortable. Erm, I think I saw him as a bit of a (..)
17 respite really, to help my situation, and of course we were happy because we'd got back together as
18 old friends, and of course it was a forming of a new- we hadn't had a relationship before, so you
19 know there was a lot to look forward to really, in the future.

20

21 Interviewer: And at that point, did you know about his PTSD? Did he know about it?

22

23 Georgia: I knew about his PTSD, um I work as a health care professional. He knows that, so I think
24 that- I would say almost invited him to talk about his experiences quite openly. Erm what I realise
25 and feel now, what I didn't see then, is that it's almost like this shroud of PTSD walks in front of him,
26 this is- what I was meeting was the PTSD which is more prominent than my husband is, and his
27 persona. He very much lives for his PTSD, very controlled by it, very much controlled by it.

28

29 Interviewer: And when did you start to realise that PTSD had such a strong hold over him, or that it
30 was controlling him?

31

32 Georgia: Not for quite a few years. I was aware of PTSD, I wasn't familiar with combat-related PTSD
33 because I don't work in a combat environment. Erm I think as with many many people you always
34 think that somebody that presents to you, you think somebody's curable, that they're mendable,
35 somebody's um- and you sort of, well I'm a carer by profession so I automatically thought, that's
36 alright we can get around this, there are things that we can do. He wasn't working at the time, um
37 being signed off and receiving a war pension, which is how he is now. Erm (..) I've gone away from
38 your question now.

39

40 Interviewer: Yeah erm can you remember when you started to realise- and what came to your
41 attention?

42

43 Georgia: I think for the first two or three years, I mean the relationship was new and young, it's like a
44 honeymoon period you could call it. You start to realise that you, I use the terminology that many
45 many people use, that you are walking around on shards of glass all the time. You have to be a little
46 bit careful what you say, when you say it. And there are certain physical aspects that you can't-
47 things like balloons, balloons can't come into the house because balloons might pop. He, like a lot of
48 people with combat-related PTSD, have an exaggerated startle response and they can't cope with
49 somebody dropping a pile of plates on the floor, someone pops a balloon, someone makes a loud or
50 unpredicted noise. There is an exaggerated startle there, it's not put on it's definitely there. And you
51 can imagine the course of adrenalin that passes through the body when that happens, must be awful
52 you know, and having quite a damming effect afterwards.

53

54 Interviewer: Did that happen before you realised what it was?

55

56 Georgia: Well we sort of realised that we had to be careful if doors were slammed or whatever. You
57 sort of pick your way around someone that's got PTSD so that you don't startle them. Even now I can
58 come into the house and because I walk in through the door with a familiarity of the house is mine, I
59 will startle him. And it's- I live here you can't do this to me, it's not fair.

60

61 Interviewer: How does he respond if you make him jump?

62

63 Georgia: I think he drifts away into his own little cuckoo land and that's what startles him out of it
64 maybe, when I come in the door he's in a different place. Not back on the- he wasn't in an action
65 field he was on a ship. But I think he can lull into a false sense of security and that's what can startle
66 him out of it. We had quite a damming experience, literally up the road when we um came to see
67 the village pantomime. This was two years into the relationship, thought it would be good fun to
68 come and see the village pantomime. Erm, I can't remember if we had a child in the pantomime at
69 the time, but we'd gone on an evening where they'd used little flashes, with flash-bangs my husband
70 called them. And this fairy appeared onstage and these flash-bangs went off. And he just had this
71 massive flashback, which made him leave the pantomime um and I think he walked home, talking to
72 a friend of his on the phone. And I'd stayed there, I can't remember the reason why, I can't
73 remember if it was because I was sitting with my children or because my child was on stage. I didn't
74 leave with him and I didn't make a fuss of him about what was going on in his mind. I just left him to
75 deal with it. So I'm fully aware of the symptoms that can occur from the PTSD but when you live with
76 somebody like that, you're constantly tiptoeing around them, trying not to upset them, rattle them,
77 you know they can have quite a- my husband can have quite an aggressive temper. So you don't
78 want to rattle that temper so you- I think over time you start to become a bit subdued.

79

80 Interviewer: Umm I was going to ask what the impact is on you of doing that?

81

82 Georgia: Yeah I can't tell you what the full impact is because I think we are only just starting to
83 realise how subdued we've been. Um one of my daughters is now speaking to somebody at school
84 and these things are starting to feed back to me, in what she's telling me. But you know of late,
85 because I work, and my hours are (..) my hours are shift work hours so they're all over the place, but
86 I do notice now that if I'm in the house in the evening, my two girls who live at home will be sitting in
87 the living room where I'm sitting. If I'm at work and I come home from work, they're both in their
88 bedrooms. They don't sit in the same place as my husband, and that's not because he's told them go
89 on get out or anything like that, I think it's because they do not find it a favourable place to be.
90 Which has been going on for I don't know how long and I didn't really realise it was going on.

91

92 Interviewer: Because I guess things become the norm in families, and you don't always realise-

93

94 Georgia: - yeah it does, and you don't really realise what is abnormal.

95

96 Interviewer: And I guess it is draining for everyone to walk on glass and to be thinking all the time
97 about what you're doing so you don't upset someone?

98

99 Georgia: You- it becomes the normality as well and you don't realise you're doing it. It is quite
100 difficult at times.

101

102 Interviewer: In terms of your relationship, have there been times it's been harder or easier, or times
103 when PTSD has been more at the forefront?

104

105 Georgia: I think, if I could put it into my words, at first in our relationship we were obviously happy,
106 everything was bright everything was rosy everything was really nice, and I feel now like there is
107 three of us in our relationship, excluding the children, there are three of us. There's me, him, and his
108 PTSD. It's like it's a big persona that was there, that was standing in front of a lot of things that
109 prohibit normality. We don't get on really well at the moment. We've been going to family therapy
110 which was sorted by the community mental health team to try and sort out some of the problems.
111 But I've got to a point where I realise I class our relationship as being unfair. Because my husband,
112 yes he is um signed off off work, he's medically retired from work, um justifiably receives a war
113 pension for being so but I expect him to do more around the house than he actually thinks he's going
114 to get away with doing. And there is a lot of ruckus about that at the moment. There's an unfair
115 balance, just unfair is the way I've had somebody say to me. It's not a fair balance and I agree with
116 that, I don't think it is a fair balance. I think there is stigma that comes with it, that my husband, like
117 many others literally came from his mother's apron strings into the services. Erm, they go from
118 having one meal served in one place to other meal service for them in another place. And I think
119 they come to expect it. But then I think, you were married for nineteen years. Did nothing change

120 you or make you? It's almost that they have this inability to get on in civilian life. But with my
121 husband's case I would very strongly suggest that because he's got this label of PTSD, he will use that
122 as his excuse for not being able to get on in civilian life. And because he receives treatment for his
123 PTSD and he goes to a treatment centre, there are other people there with similar um- who have
124 been labelled with PTSD, not necessarily for the same reason, but combat-related PTSD. So he's sort
125 of in a gang, a group, of people and they spend a lot of Facebook time speaking to each other. It's
126 almost like these are the only people who are acceptable to be spoken to, because they understand.
127 And that-that moves over to the emotional side of the relationship, because you are pushed out of
128 this relationship. I could quite willingly say that I think my husband would rather have his PTSD than
129 he would save his marriage. That may just be him, but that's how I feel. And of course, that does
130 hurt you emotionally because you-you are not genuinely in a relationship with someone, you've got
131 something bigger that's in between you, that's stopping you from being together. That I do-I do find
132 hard.

Appendix I

Transcription notation

-	Interruptions or sudden change of topic
(..)	Pauses in brackets with dots representing the length of the pause
(yeah, mm)	Overlapping speech
and he said “no”	Reported speech by a third person
[both laugh]	Actions (laughing, crying, etc)
Interviewer:	Indicates speaker. New speaker begins on separate line

In Results section only

...	Indicates portion of text removed from quotation
-----	--

Appendix J

Excerpt from MAXQDA coding frame

The screenshot displays the MAXQDA software interface with a hierarchical code system. The main window shows a tree structure of codes, with the following categories and sub-codes:

- Code System**
 - MY WOUNDED SOLDIER OR A MAN BEHAVING BADLY?**
 - Making meaning:working out the problem
 - Veterans are forgotten and overlooked once they've served
 - Asking self whether there were signs of problem before
 - Pleasing/protecting dad
 - Positives of relationship/veteran
 - Diagnosis means they are sick and can be fixed
 - Diagnosis means they are sick and its not their fault
 - Impact of hearing war trauma stories
 - Not knowing about traumatic events until later
 - Family system affected by trauma
 - Empathy for war experiences
 - Upsetting but not traumatic
 - Change of identity: veteran is a different person/imposter
 - Wanting old daddy back
 - PTSD has a life of its own
 - Veteran wants to keep PTSD / serves a function
 - Loss of old husband; Will he come back again?
 - Grief reaction
 - Sick or bad person?
 - PTSD is not an excuse for bad behaviour
 - Shift in perception of normal/trying to work out what normal is
 - Stuck in relationship
 - Til death do us part: role of marriage
 - Knowing you're not the only one in the boat
 - Stigma associated with MH
 - ILL-EQUIPED FOR FAMILY & CIVILIAN LIFE**
 - Repressed then triggered later/ emotions come out at some point
 - Huge challenge of adjusting to civvy street
 - Avoidance of family life/treatment
 - Alcohol - self-medicating
 - Behaviour is adaptive in AF but not conducive to family life
 - Control/OCD
 - Not prepared for the real world - lacking skills and knowledge
 - Lack of flexibility: military routines
 - Inability to decisions/shape own life

Appendix K

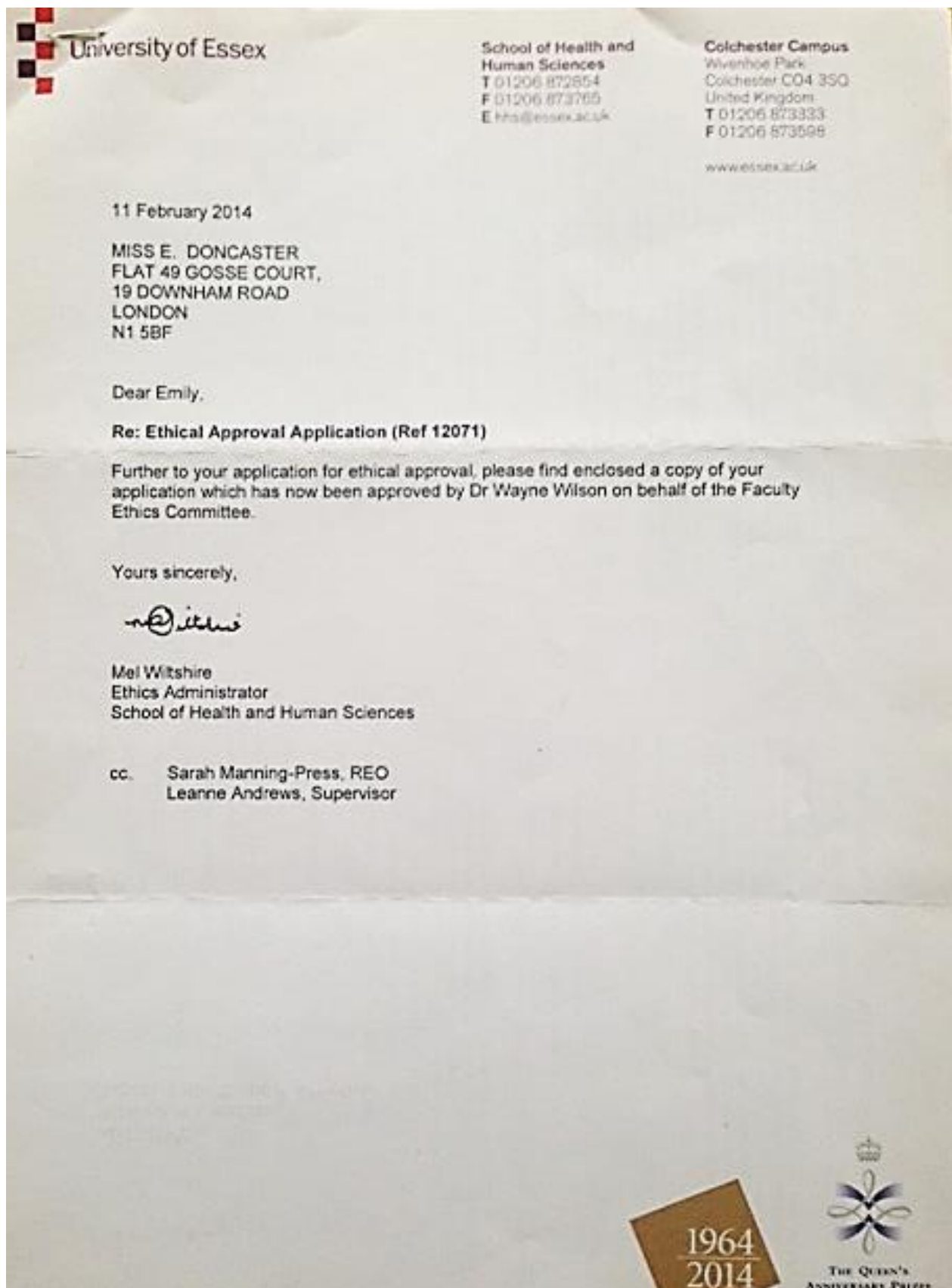
Excerpt from reflective diary

Second interview

...I noticed similar themes as to the first interview in terms of walking on eggshells and husband being portrayed as a trigger/threat. Participant seemed to report similar symptoms as husband's PTSD but hyper-vigilance was in relation to monitoring husband rather than reminders of war trauma... for her the process of secondary traumatisation seemed to be in relation to her husband's unpredictability, living with anger and a lack of intimacy, rather than hearing about traumatic events....I personally felt low after this interview and hopeless/trapped. It was distressing to hear about her regrets and feeling that life would always be like this... I noticed that I steered away from asking about any positive elements of living with PTSD as I anticipated it would provoke anger in her or disbelief, as it was so far from her story. However this is an important part of my topic guide so I will think about how to deal with this for next interviews, in a way that is sensitive to their distress but also allows me to ask the question. I also noticed feeling hyper-vigilant myself as I was unsure about where her husband was for part of the interview...

Appendix L

Confirmation of ethical approval and amendments



Application for Ethical Approval of Research Involving Human Participants

This application form should be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers), human remains and body parts, embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to, medical, genetic, financial, personal, criminal or administrative records and test results including skeletons, photographs). Research should not commence until written approval has been received from Departmental Research Director, Faculty Ethics Committee (FEC) or the University's Ethics Committee. This should be done in order when writing a grant for the project.

Applications should be made on this form, and submitted electronically, to your Departmental Research Director. A signed copy of the form should also be submitted. Applications will be assessed by the Research Director in the first instance, and may then proceed to the FEC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, covering material, etc.) should also be attached to this form.

A full copy of the signed application will be retained by the Department/School for 6 years following completion of the project. The signed application form cover sheet (two parts) will be sent to the Research Governance and Planning Manager in the RIG as Secretary of the University's Ethics Committee.


- Title of project**
Living with combat related trauma: Experiences of partners of UK veterans
- The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.**
Do you object to the title of your project being published? Yes ☐ No ☒
- This Project is:** ☐ Staff Research Project ☒ Student Project
- Principal Investigator(s) (students should also include the name of their supervisor)**

Name	Department
Dr Jayne Doherty (PI)	School of Health and Human Sciences
Dr Lesene Andrews (Local supervisor)	School of Health and Human Sciences
Dr Susan McPherson	School of Health and Human Sciences
Dr Syd Hasky	North Essex Partnership NHS Foundation Trust
- Proposed start date:** March 2014
- Probable duration:** 11 months
- Will this project be externally funded?**
If Yes, Yes ☐ No ☒
- What is the source of the funding?**

4. **If external approval for the research has been given, then only this cover sheet needs to be submitted. External ethics approval obtained (attach evidence of approval)** Yes ☐ No ☒

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is to the best of my knowledge, complete and correct. I have read the University's *Guidelines for Ethical Approval of Research*, completed and signed the necessary forms and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Self-regulating Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I have accepted to identify all risks related to the research that may arise in conducting this research and acknowledge the right of withdrawal and the rights of the participants.

Signature(s): 
Name(s) in block capitals: Emily Domeneite
Date: 7/1/14


Supervisor's endorsement (Student Projects only):
 I have read and approved both the research proposal and this application.
Supervisor's signature: _____

Outcome:

The Departmental Director of Research (Doherty) has reviewed this project and considers the methodological/scientific aspects of the proposal to be appropriate to the tasks proposed. The Data consent form (researcher(s) have the necessary qualifications, experience and facilities to conduct the research as set out in this application, and to deal with any contingencies and considerations that may arise.

This application falls under Annex B and is approved on behalf of the FEC.

This application is referred to the FEC because it does not fall under Annex B.

Signature(s): 
Name(s) in block capitals: Jayne Doherty
Department: HHS
Date: 7/2/14

The application has been approved by the FEC ☐
 The application has not been approved by the FEC ☐
 The application is referred to the University Ethics Committee ☐

Signature(s): _____
Name(s) in block capitals: _____
Faculty: _____
Date: _____

Dr Wayne Wilson
School of Health and Human Sciences Ethics Committee
University of Essex

03 September 2014

Dear Dr Wilson

Re: Request for minor amendment to ethical approval (ref: 12071)

Thank you for granting ethical approval for my doctoral thesis, entitled 'Living with combat-related trauma: Experiences of partners of UK veterans' (reference: 12071) in February 2014.

The proposal you reviewed stated that I would recruit participants who met the following criterion: *they were in a relationship with the veteran whilst they were deployed and before the point that they began to show symptoms of traumatisation*. During my recruitment period, it has been very difficult to recruit people who meet this criterion and are still currently in a relationship with a veteran, partly due to the pressures that both deployment and living with trauma places on a relationship.

After discussion with my research supervisors, we have concluded that the experience of being in a relationship with someone through deployment is not central to my research questions. Instead, what is important is the impact of living with the effects of trauma for them individually, and for their relationship. Therefore, I would like to request to remove this criterion from my inclusion criteria to increase the likelihood that I will recruit an acceptable number of participants to my study.

I have attached a revised version of my participant information sheet, interview topic guide and demographic questionnaire, with tracked changes where modifications have been made.

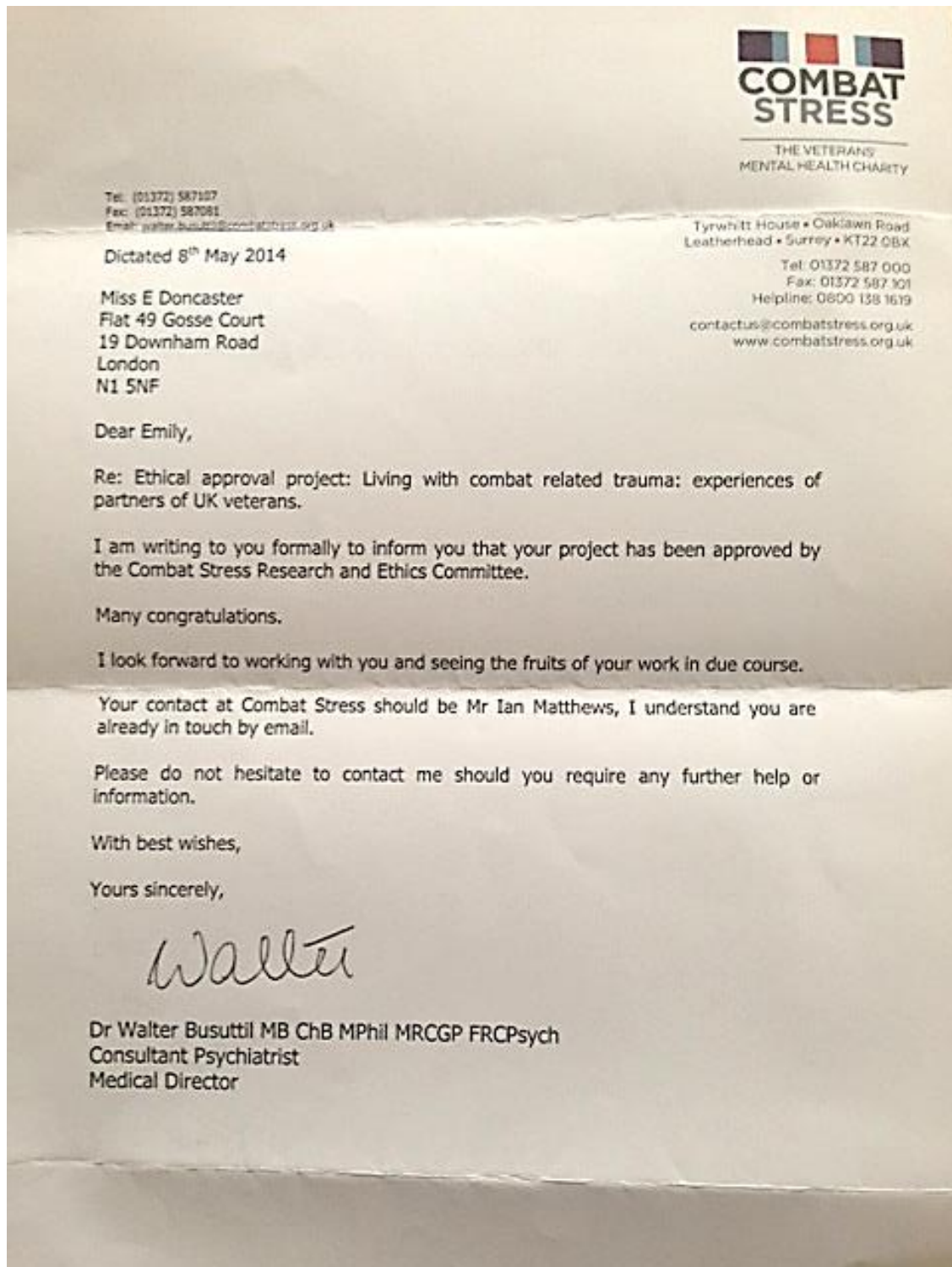
I believe that these measures will allow the recruitment phase of my research to get back on track. Thank you for considering this request.

Yours sincerely

Emily Doncaster
Trainee Clinical Psychologist

Discussed and agreed with departmental supervisors: Dr Leanne Andrews and Dr Susan McPherson

*Amended Documents
received & approved. 25/9/2014
W. Wilson*



Appendix M

Letter to participants' general practitioners (GP)

Dear General Practitioner

I am writing to you to inform you that your patient participated in a research study focusing on the experiences of partners who live with veterans with PTSD/trauma. This is a research project that I am undertaking as part of the Doctorate in Clinical Psychology at the University of Essex. The study has been given ethical approval by the University of Essex Science and Health Faculty Ethics Committee and recruitment of participants has been assisted by Combat Stress, the veterans' mental health charity.

During the course of the research interview, there were signs that your patient is currently experiencing a significant level of psychological distress, which may benefit from some intervention or support. Your patient and I discussed this together and it was agreed that they would book an appointment with you and give you this letter.

If you would like to discuss this further, please do not hesitate to contact me on edonca@essex.ac.uk or 07527634317.

Yours faithfully

Emily Doncaster

Trainee Clinical Psychologist

University of Essex

edonca@essex.ac.uk / 07527634317