

Living with military partners diagnosed with PTSD.

The phenomenon of secondary traumatization.

by

Joanna Magdalena Cobley

The Research Dossier submitted to The University of Wolverhampton for the Practitioner

Doctorate: Counselling Psychology Award: D.Couns.Psych

May 2015

## Abstract

**Objective:** In the study the subjective experiences of UK partners of veterans and military personnel who were diagnosed with Posttraumatic Stress Disorder (PTSD) and how they cope with the impact of their experiences were explored. The study also examines the possible existence of the secondary traumatization (ST) phenomenon in this context. **Method:** This is a qualitative study which draws on Interpretative Phenomenological Analysis (IPA). Semi-structured interviews were conducted with six female participants, all of whom achieved a cut-off score of 30 on the PTSD Checklist for Civilians questionnaire (the PCL-C). **The main findings:** 1. Participants were, in general, negatively affected by their experiences of living with their military partners with PTSD, regardless of the length of their relationships. 2. Of the military partners' PTSD symptom clusters, participants were mostly affected by avoidance and hyperarousal. 3. Participants, in general, were traumatised by their home experiences and this could be conceptualised as ST. 4. The most important element in ST development was ongoing, prolonged exposure to negative impacts of military partners' PTSD. **Conclusions:** The study contributes to knowledge on the impacts of military-related PTSD on partners. By doing so it provides evidence of reciprocal effects of PTSD on all family members, suggesting that PTSD should be perceived as a family condition. The study also highlights the existence of ST phenomenon. **Recommendations:** 1. Recognition of ST, as a mental health condition or phenomenon, among professionals, general public and also partners themselves. 2. Recognition of PTSD as a family condition and its reciprocal impacts. 3. Introduction of early support in recognising, diagnosing and treating PTSD and ST.

Research dossier structure

## **CHAPTER 1 - INTRODUCTION**

### **1.1 AN INTRODUCTION TO THE RESEARCH TOPIC**

### **1.2 RESEARCH QUESTIONS**

### **1.3 METHODOLOGY AND DESIGN OF THE STUDY**

### **1.4 TERMS WITHIN RESEARCH DOSSIER**

## **CHAPTER 2 - LITERATURE REVIEW**

### **2.1 INTRODUCTION AND SCOPE OF REVIEW**

### **2.2 POSTTRAUMATIC STRESS DISORDER IN MILITARY**

**2.2.1 Empirical evidence of Posttraumatic Stress Disorder among military personnel.**

**2.2.2 Explanations for differences in Posttraumatic Stress Disorder rates.**

### **2.3 POSTTRAUMATIC STRESS DISORDER AND RELATIONSHIPS**

**2.3.1. Partners' distress.**

**2.3.2 Relationship breakdown.**

**2.3.3 Variables intrinsic to partners.**

**2.3.4 Impact of particular Posttraumatic Stress Disorder characteristics on relationships.**

**2.3.5 Research on the British population.**

### **2.4 SECONDARY TRAUMATIZATION**

**2.4.1 Empirical studies.**

**2.4.2 Development of secondary traumatization.**

**2.4.2.1 *Empathy and desire to help.***

*2.4.2.2 Disclosure.*

*2.4.2.3 Ongoing exposure to military partners' Posttraumatic Stress Disorder symptoms.*

### **2.4.3 CONTROVERSIES**

### **2.4.4 THEORETICAL EXPLANATIONS FOR THE DEVELOPMENT OF SECONDARY TRAUMATIZATION**

### **2.4.5 IMPORTANCE OF RESEARCH ON SECONDARY TRAUMATIZATION**

## **CHAPTER 3 - METHODOLOGY**

### **3.1 QUALITATIVE METHODOLOGY**

### **3.2 INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS**

#### **3.2.1 PHILOSOPHY AND EPISTEMOLOGY**

#### **3.2.2 STRENGTHS OF INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS**

### **3.3 SCREENING TOOL**

### **3.4 RESEARCH METHOD**

#### **3.4.1 PARTICIPANTS- SAMPLING AND RECRUITMENT**

*3.4.1.1 Inclusion criteria.*

*3.4.1.2 Sampling strategy.*

### **3.5 DATA COLLECTION PROCEDURES**

### **3.6 DATA ANALYSIS**

### **3.7 ETHICAL CONSIDERATIONS**

### **3.8 REFLEXIVITY**

### **3.9 VALIDITY AND QUALITY**

## **CHAPTER 4 - ANALYSIS OF FINDINGS**

### **4.1 CHARACTERISTICS OF THE SAMPLE**

### **4.2 MAJOR THEMES**

#### **4.2.1. UNPREDICTABILITY OF MILITARY PARTNERS' BEHAVIOURS AND MOODS**

*4.2.1.1 Findings.*

*4.2.1.2 Discussion.*

#### **4.2.2 HYPERVIGILENCE**

*4.2.2.1 Findings.*

*4.2.2.2 Discussion.*

#### **4.2.3 TRIGGERS TO MILITARY PARTNERS' BEHAVIOURS AND MOODS**

*4.2.3.1 Findings.*

*4.2.3.2 Discussion.*

#### **4.2.4 A SENSE OF LOSS**

*4.2.4.1 Findings.*

*4.2.4.2 Discussion.*

## **4.2.5 ADAPTATIONS**

### ***4.2.5.1 Findings.***

### ***4.2.5.2 Discussion.***

## **4.2.6 LONELINESS**

### ***4.2.6.1 Findings.***

### ***4.2.6.2 Discussion.***

# **CHAPTER 5 – GENERAL DISCUSSION, RECOMMENDATIONS, AND CONCLUSIONS**

## **5.1 SUMMARY OF FINDINGS**

### **5.1.1 PARTNERS' EXPERIENCES**

### **5.1.2 COPING WITH THE IMPACT**

### **5.1.3 SECONDARY TRAUMATIZATION**

## **5.2 IMPLICATIONS FOR FUTURE POLICIES AND CLINICAL PRACTICE**

### **5.2.1 RECOGNITION OF SECONDARY TRAUMATIZATION**

### **5.2.2 EARLY SUPPORT**

### **5.2.3 RECOGNITION OF PTSD AS A FAMILY CONDITION AND ITS RECIPROCAL IMPACT**

## **5.3 LIMITATIONS OF THE STUDY**

## **5.4 SUGGESTIONS FOR FUTURE RESEARCH**

## **5.4 CONCLUSIONS- SIGNIFICANCE OF THE STUDY**

## CHAPTER 6 – CRITICAL REVIEW

### 6.1 REFLECTIONS ON THE RESEARCH PROCESS

### 6.2 REFLECTIONS ON MY SELF-DEVELOPMENT

References

Appendices

**Appendix 1** The PCL-C Checklist

**Appendix 2** Letters requesting, or granting, consent from any collaborating institutions

**Appendix 3** Formal information sheet about the study.

**Appendix 4** The Poster and Leaflet.

**Appendix 5** Invitation to the study

**Appendix 6** Information sheet for participants about the study

**Appendix 7** Demographic questionnaire

**Appendix 8** Consent Form

**Appendix 9** The covering letter

**Appendix 10A** A debriefing sheet to be used in individual debriefings with participants who completed the PCL-C Checklist.

**Appendix 10B** A debriefing sheet to be used in individual debriefings after semi-structured interviews.

**Appendix 11** An interview schedule

**Appendix 12** Participant information sheet given to participants before the semi-structured interview (if the first part of the research (PCL-C Checklist) was done on the phone).

**Appendix 13** Participants' log



## Acknowledgments

I would like to dedicate this thesis to all of my participants, who trusted me as a researcher and generously shared their personal experiences. They invited me to their inner worlds, despite their uneasiness at times, and did not hesitate to be truly honest and brave in revealing their vulnerabilities and the true nature of their lives. I am enormously grateful to them and hope that this research allowed them to raise awareness of issues facing many women living with their military partners with PTSD.

This thesis could not have been completed without Dr Wendy Nicholls's support and guidance. Her insightful comments made an invaluable contribution to the project. Every time she shared her reflections or suggestions with me, I was able to appreciate the depth of her expertise and insightfulness, which challenged me as a researcher and enhanced the quality of my work. She guided me through the theoretical and practical aspects of the research process, and was always motivational and approachable. It was a privilege to have her as my supervisor.

Finally, I would like to thank my husband, David, the love of my life, who has been my rock and the source of everlasting wisdom, unconditional love and support throughout the whole research process. It is his continuous belief in me which allowed me to lift myself up after periods of self-doubt during which I questioned if I was capable of doing this kind of research. He did not seem to doubt in me even for a second. Instead, he would just listen patiently to my complaints and repeat one sentence over and over again: "It's difficult but you will get there". And I did get there. I did get there but it was only thanks to him.

## Declaration

This Research Dossier is an original work of Joanna Magdalena Cobley, who was supported in the research process by her supervisors Dr Wendy Nicholls and, in the early stages, by Dr James Porter.

Joanna Magdalena Cobley is the sole author of the Research Dossier and she also owns the copyright of the Research Dossier.

The Research Dossier has not been presented previously to the University or to any other academic or non-academic professional body.

Also, throughout the Research Dossier all data was anonymised and potentially identifiable information, relating to study participants, has been removed.

Signature: Joanna Cobley

Date: 06.05.2015

## WORD COUNT SUMMARY

The word count summary excludes tables.

<b>Chapter</b>	<b>Page number</b>	<b>Word Count</b>
Chapter 1 – Introduction	97	1,053
Chapter 2 - Literature Review	101	10,241
Chapter 3 - Methodology	134	5,562
Chapter 4 - Analysis of Findings	154	15,946
Chapter 5 - General Discussion, Recommendations, and Conclusions	206	3,073
Chapter 6 - Critical Review	217	1,538
TOTAL		37,413

## Acronyms

CATS -Couple Adaptation to Traumatic Stress

*DSM – the Diagnostic and Statistical Manual of Mental Disorders*

*DSM-IV – The Fourth Edition of Diagnostic and Statistical Manual of Mental Disorders*

*DSM-5 – The Fifth Edition of Diagnostic and Statistical Manual of Mental Disorders*

IPA - Interpretative Phenomenological Approach

PCL - PTSD Checklist

PCL-C - PTSD Checklist for Civilians

PTSD- Posttraumatic stress disorder

ST- secondary traumatization

STS - secondary traumatization stress

## **CHAPTER 1 - INTRODUCTION**

The introduction chapter outlines the research topic and research questions, which explore the shared lived experiences of participants living with military partners who are serving military personnel or veterans and the possible presence of secondary traumatization. The chapter also briefly describes the methodology and study design, as well as defining terms used throughout the thesis.

### **1.1 AN INTRODUCTION TO THE RESEARCH TOPIC**

The aim of making a positive change to people's well-being is at the heart of all disciplines of psychology and research. Investigating people's experiences and conditions informs and enhances professionals' knowledge, policy and practice, and counselling psychologists have an obligation to contribute to the field of research. This project on secondary traumatization (ST) of UK partners of military personnel with posttraumatic stress disorder (PTSD) aims to make a contribution to the area of psychology, focusing on the particular social context of the military forces.

My interest in the subject of this doctorate thesis arose from living in the UK, a country that was heavily involved in recent major military conflicts in Afghanistan and Iraq. This topic was prominent in the media over a long period of time, focusing on war casualties and physical and mental health wounds that soldiers suffered. Although the news was disturbing, my thoughts related also to the families of these army personnel, thinking of them as silent victims of war actions. This was also influenced by experiences of the clinical placement in Physical Health Psychology, where I understood that clients' illnesses and conditions were, in fact, affecting the whole family system and were becoming family illnesses. Also, as my particular interest in psychology is adult mental health, I focused in my reflections, in relation to military families, on military personnel's mental health conditions

affecting other family members. This resulted in wanting to explore further how military personnel's PTSD affects their families, in particular their partners, and if the phenomenon of ST can encapsulate this impact.

## **1.2 RESEARCH QUESTIONS**

The project aims to investigate subjective experiences and the impact of living with partners who are diagnosed with military-related PTSD. In order to achieve this aim the first research question asks: What are partners' experiences of living with military partners with PTSD? This research question could have a secondary impact in 'unsilencing' the societal group of partners of military personnel and veterans diagnosed with PTSD, whose emotional battles on the home front do not receive appropriate recognition. As a result, this research brings to attention the element of social justice, which British counselling psychology is still hesitant to do (Harrison, 2013; Cutts, 2011).

Another important issue that the project aims to explore is how partners deal with the impacts of their experiences. This is addressed by the second research question, which asks: How do partners cope with the impact of living with military partners with PTSD?

The project also aims to explore the potential phenomenon of ST, experienced by partners of military personnel and veterans diagnosed with PTSD. Hence the final research question asks: Do partners living with military partners with PTSD experience secondary traumatization and, if so, how is it represented? Addressing this research question should contribute to the discussion on the impact of family member's PTSD on others in the family, providing a better understanding of the complexity of PTSD and its reciprocal relational impact. This could inform future policies and psychological interventions when supporting clients with PTSD and their families, such as psycho - education, self - screening and appropriate support after experiencing ST.

### 1.3 METHODOLOGY AND DESIGN OF THE STUDY

The project was a qualitative study which allows for fully appreciating subjective and individual experiences of participants, who become validated and empowered in the research process (Lyons & Coyle, 2007). Interpretative Phenomenological Analysis (IPA) was used as the research method, enabling in-depth investigation and interpretation of participants' life experiences while taking into account different contexts in which they emerge (Larkin, Watts & Clifton, 2006). The IPA qualitative methodology is reflected in the choice of the research questions, the data collection and the analysis of the data.

Additionally, the PTSD Checklist for Civilians (the PCL-C) was used a screening tool of potential participants for the study. The PCL-C is a self-report questionnaire, which can be used to identify participants who have “a high probability of a disorder and are likely to benefit from a thorough clinical evaluation” (McDonald & Calhoun, 2010, p.977). Using the screening tool increased the chances of recruiting participants with potential PTSD. This is particularly relevant in regards to ST, which is characterised by PTSD-like symptoms. Participants who achieve a selected cut-off score on the PCL-C questionnaire were invited to semi-structured interviews, conducted and analysed using IPA methodology.

### 1.4 TERMS WITHIN RESEARCH DOSSIER

**Military partners:** army and Royal Air Force military personnel who are in established relationships with study participants.

**Military personnel:** actively serving military personnel or veterans.

**Posttraumatic Stress Disorder:** an anxiety disorder which results from being exposed to traumatic event(s) involving threatened death, serious injury or sexual violence but also - a recently recognised PTSD criterion in the fifth edition of *Diagnostic and Statistical Manual*

of *Mental Disorders* (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013) finding out about these events from someone who has been through them. PTSD is characterised by four clusters of symptoms which are: intrusion or re-experiencing; avoidance; negative changes in arousal and reactivity linked with a traumatic event; negative changes in cognitions and mood. This is a more comprehensive range of criteria than that contained within the previous version of the *Diagnostic and Statistical Manual of Mental Disorders* (4<sup>th</sup> ed.; *DSM-IV*, American Psychiatric Association, 1994), which did not include the changes in conditions and mood as a separate cluster of symptoms.

**Secondary traumatization stress (STS):** a phenomenon of developing PTSD-like symptoms as a result of finding out about a traumatizing event experienced by a person who is in close contact with and emotionally connected to a traumatized person. This person also has an overwhelming feeling of compassion and empathy for survivors of traumatic experiences and the desire, if not a sense of obligation, to help and support them (Figley, 1995). As this term is interchangeably used with ST, it will be used in the project only if specifically referred to in the studies or theories.

**Secondary traumatization (ST):** a term interchangeably used with secondary traumatization stress.



## CHAPTER 2 - LITERATURE REVIEW

### 2.1 INTRODUCTION AND SCOPE OF REVIEW

The United Kingdom (UK) has been involved in a significant number of military conflicts around the world since the 1<sup>st</sup> World War. Involvement in the most recent conflicts in Iraq and Afghanistan alone resulted in the deployment of over 100,000 UK reserve and regular service personnel (Iversen et al., 2009) many of whom had encountered combat exposure and were deployed on numerous occasions during those conflicts. This has created a concern regarding potential short and long-term effects on the mental health of military personnel (Iversen & Greenberg, 2009). The Kings Cohort study conducted on UK military personnel who were deployed to the 2003 Iraq war established that 20% of common mental health disorders were present among them (Hotopf et al., 2006). A second UK cohort study on military personnel serving during recent conflicts in Afghanistan and Iraq between 2003 and 2009 established a total prevalence of mental health disorders within the military population at 19.7% (Fear et al., 2010) and 17% and 16% for UK armed forces who, at the time of the study were deployed in Afghanistan and surveyed in 2010 and 2011 retrospectively (Jones et al., 2014). In another study on the UK military during the main fighting period of the Iraq war the prevalence of mental health disorders was established at even higher rate of 27.2% (Iversen et al., 2009). The common mental health disorders experienced by military personnel quoted were PTSD (Hoge et al., 2004; Iversen et al., 2009), but also depressive disorder, anxiety, behavioural disorders (MacManus et al., 2012), and alcohol abuse (Fear et al., 2010). However, it is not only military personnel who become the victims of those disorders (Galovski & Lyons, 2004) but their families and friends, who are may also be affected by whatever they are going through. They may be seen, in fact, as silent victims of military conflicts who face battles on the 'home front', which might result in experiencing secondary traumatization (ST).

This critical review will summarise findings about PTSD prevalence among military populations and discuss the impact of PTSD on romantic relationships. The phenomenon of ST, which is believed to be one of the possible consequences of sharing lives with partners diagnosed with PTSD, will then be presented and discussed. It will be also argued that, given the high prevalence and severe psychosocial outcomes experienced by this social group, there is a need for more research to inform intervention planning, policies and clinical practice.

The books and peer-reviewed journal articles reviewed here were obtained through a literature search on Google Scholar and online sources of the Wolverhampton University Library using databases such as PsycINFO or Web of Science. Online searches made use of key words such as military, soldiers, veterans, PTSD, ‘partners of military personnel’, ‘secondary traumatization’, families and ‘secondary traumatic stress’. The researcher continued to search online for the most relevant literature throughout most of the research process, including regular checks on the ‘National Center for PTSD’ website. Another method of literature searching was checking bibliographies of articles found for other relevant books and articles.

## **2.2 POSTTRAUMATIC STRESS DISORDER IN MILITARY**

Military-related PTSD has been frequently highlighted in the media. However, research on military personnel taking part in recent military conflicts in Iraq and Afghanistan reported a surprisingly wide range of PTSD prevalence rates for deployed soldiers of between 1.8% (Jones et al., 2014) and 31% (Lapierre, Schwegler & LaBauve, 2007). The highest prevalence rates were noted in studies on deployed United States (US) soldiers and among Australian Defence Forces at a moderate level of 8.3% (Australian Centre for Posttraumatic Mental Health, 2012), whereas UK studies reported much lower rates. This could suggest that PTSD among UK military personnel might not be a significant issue, leading to an

assumption that this would be the same case with ST, which results indirectly from another's person PTSD. However, it is believed that low PTSD rates reported in UK studies, might not mirror the full reality of PTSD and likelihood of ST prevalence among military personnel's partners. Some explanations for this will be discussed in this section.

### **2.2.1 Empirical evidence of Posttraumatic Stress Disorder among military personnel.**

Two major UK cohort studies on UK soldiers deployed in Iraq (Hotopf et al., 2006) and, in the case of the second study, Afghanistan (Fear et al., 2010) reported quite low probable PTSD rates. This contrasts with studies on US soldiers deployed to Iraq, conducted 3-4 months after deployment, which found PTSD prevalence rates of 12.6% (Hoge et al., 2004), 20.7% and 21.5% (LeardMann, Smith, Smith, Wells & Ryan, 2009), 7.3% (Thomas et al., 2010) and, for soldiers deployed to Afghanistan, 6.2% (Hoge et al., 2004).

The first of the UK cohort studies (Hotopf et al., 2006) did not find any significant worsening in mental health outcomes as a result of UK soldiers' deployment in Iraq. The results from this study also revealed a probable PTSD prevalence rate of 4%, which did not rise for the first six months after deployment in Iraq in 2003. The second UK cohort study (Fear et al., 2010) also revealed that the prevalence of mental health disorders among UK soldiers deployed to both Iraq and Afghanistan "remained stable between 2003 and 2009" (Fear et al., 2010, p.1792). The study revealed a slightly higher PTSD prevalence rate of 4.2% for deployed regulars, during this period.

Findings from UK cohort studies seem surprising in the light of evidence suggesting that reported PTSD prevalence increases with time after deployment (Fikretoglu & Liu, 2012). This was also confirmed in studies on Vietnam veterans, which established a prevalence rate of PTSD 15 or more years after the war at 15.2% for men and 8.5% for women (Schlenger et al., 1992). In another study, conducted 20-25 years after the Vietnam

war, the prevalence rate was 25.3% for male veterans and 20% for female veterans (Schnurr, Lunney, Sengupta & Waelde, 2003). Moreover, studies on US military personnel deployed in the recent military conflicts in Iraq and Afghanistan suggest that PTSD rates increase with time. In a study on US soldiers deployed to Iraq, PTSD prevalence rates rose as time elapsed since the traumatic event and, at 12 months, were established at between 7.3% and 23.7% for active soldiers and at between 11.3% and 30.5% for reservists, depending on the PTSD measurement used (Thomas et al., 2010). In another US study, using two different PTSD measurements, 7.3% and 8.6% of participants had new onset symptoms or a diagnosis of PTSD, in comparison to baseline data from three years before (LeardMann et al., 2009).

UK studies generally present much lower PTSD prevalence than other studies. A study conducted in Iraq, on a representation of 15% of the deployed UK force, revealed a probable PTSD rate of 3.4% (Mulligan et al., 2010), while another study revealed a 4.8% PTSD prevalence rate for military taking part in the Iraq conflict (Iversen et al., 2009). Another study, conducted in Afghanistan, on UK armed forces personnel deployed to Afghanistan in 2010 and 2011 reported even lower probable PTSD prevalence rates of only 2.8% in 2010 and 1.8% in 2011 (Jones et al., 2014). However, the rates were measured while still in deployment, when military personnel might still feel protected within the military environment. Also, findings from UK studies that focus only on samples of military populations who were referred to mental health services present much higher rates of PTSD than in other UK studies reviewed in this section. In an evaluation of six community mental health pilots for UK armed forces veterans, overall rates of PTSD were found at 14% (Dent-Brown, 2010). Moreover, the mental health charity Combat Stress reported a staggering number of three-quarters of their clients from 2003 to be diagnosed with PTSD (van Hoorn et al., 2013). Interestingly, the PTSD rate was established at 10% among military personnel who approached Ministry of Defence Community Mental Health (DCMHs) for outpatient care

between 2007-2013 (Ministry of Defence, 2013). This is a higher number in comparison to the data from 2010, according to which only 4.5% of military personnel in DCMHs had diagnosis of PTSD (Ministry of Defence, 2011).

### **2.2.2 Explanations for differences in Posttraumatic Stress Disorder rates.**

The most obvious reason for low prevalence rates of PTSD in the UK studies seems to be more strict PTSD diagnostic criteria adopted in the studies, in comparison to, for example, US studies. In UK studies, the most commonly used PTSD measurement tool is the PCL cut-off score of 50, whereas in some US studies a less strict criterion is used - the *DSM-IV* (4<sup>th</sup> ed.; *DSM-IV*, American Psychiatric Association, 1994) criteria alone. The impact of using particular measurements can be portrayed on the example of two US studies, described above (Thomas et al., 2010; LeardMann et al., 2009). In, for example the study conducted by Thomas et al., (2010), the higher prevalence rates were obtained when using *DSM-IV* criteria alone, while the lowest rates were obtained when using *DSM-IV* criteria (4<sup>th</sup> ed.; *DSM-IV*, American Psychiatric Association, 1994), a PTSD Checklist (the PCL) cut-off score of 50 and the presence of severe functional impairment (Thomas et al., 2010). However, even when comparing UK and US studies that use the PCL cut-off score of 50, the differences between levels of PTSD prevalence are still significant, with estimated UK prevalence rates much lower.

The differing results from US and UK studies applying the same measurement and case definition might be due to the fact that the UK soldiers were less exposed to combat actions and serious injuries than US soldiers (Sundin et al., 2014). Also, the majority of UK studies focused on randomized samples of entire deployed populations (Hotopf et al., 2006), whereas US studies used purposively sampled populations, such as combat infantry units (Hoge et al., 2004). This is significant as the association between having a combat role and higher combat exposure has been shown to be strongly associated with developing PTSD

(Fear et al., 2010; Mulligan et al., 2010). This was, for instance, confirmed in one of UK studies where the probable PTSD prevalence rate was established at 6.9% for regulars deployed in combat service, but only 2.1% for those in a combat service support role (Fear et al., 2010). This suggests that PTSD levels among military personnel might significantly vary for particular groups of soldiers within the Armed Forces, which studies on random samples would not reflect. This would also have an immediate impact on reporting cases of ST. Also, if UK military personnel serve in more combat roles and have more combat exposure in future conflicts, more military personnel would likely develop PTSD, leading to possible traumatization of their family members.

Moreover, studies on US soldiers included more reservists in their participants' sample, as they constitute one third of US forces, more than in the UK Armed forces. It has been proven in numerous studies that deployed reservists have a higher prevalence of PTSD as compared to the deployed regular Army (Fear, et al., 2010; Harvey et al., 2012). Reservists' PTSD symptoms were identified as being responsible for problems at home during and after the deployment (Browne et al., 2007). This means that relationships involving this population might be at even higher risk of relationship distress. This is also an important factor in terms of the future of UK Armed Forces, as by 2020 there will be 112,000 soldiers and Reserve strength will be 30,000, which represents an envisaged increased proportion of reservists (Transforming the British Army, 2013). This means that more members of Armed Forces might be at risk of developing PTSD in the future, leading to increasing risk of ST development.

Another reason for differences in reported PTSD rates in studies might be “cultural and organisational differences” (Hotopf et al, 2006, p.1740) between populations of studies from different countries. In the US, for example, “PTSD and other mental health conditions may have a wider currency and legitimacy... where, perhaps for cultural reasons, reporting

symptoms is easier” (Forbes, Fear, Iversen & Dandeker, 2011, p.18). In the UK, the Ministry of Defence does not even hold records of the total number of UK veterans, which means that the number of veterans with diagnosed or undiagnosed PTSD is unknown (Ministry of Defence, 2014). In the US, however, there is even a separate governmental agency which offers help and support to veterans (Pinder et al., 2011). As a result of these organisational attitudes towards mental health conditions among military personnel, it is possible that UK military personnel experiencing severe mental health problems might decide not to take part in studies. They might diminish or deny their problems, or have a stigmatized perception of mental health issues and feel ashamed to ask for help (Palmer, 2012). This might mask a more accurate PTSD prevalence rate among UK military personnel and probable ST rates experienced by military personnel’s partners. This might also explain differences in response rates in UK and US cohort studies. In UK cohort studies, response rates were 62.3% (Hotopf et al., 2006) and 56% (Fear et al., 2010), while in a US cohort study the rate was 71% (LeardMann et al., 2009).

An additional explanation for differences in PTSD prevalence rates is the socio-demographic differences between sample populations, which make the US population more vulnerable to developing PTSD (Jones et al., 2012). The vulnerability factors within US forces were younger age, lower rank soldiers (Forbes et al., 2011), lack of experience and education (Sundin et al. 2014; Jones, et al, 2014). This suggests, however, that UK military personnel who fall into these social groupings could be more prone to PTSD development. However, due to the cultural and organisation differences, mentioned above, they might not want to report their PTSD symptoms.

### **2.3 POSTTRAUMATIC STRESS DISORDER AND RELATIONSHIPS**

PTSD can have a devastating impact both on military personnel’s mental health and quality of life and social, occupational, parental and marital functioning (Schnurr, Lunney,

Bovin & Marx, 2009). This, consequently, has an impact on other family members (Australian Centre for Posttraumatic Mental Health, 2007), their relationship quality and is a source of partners' different forms of distress and struggles. This multi-layered negative impact of PTSD can be explained by the fact that romantic relationships compose of intertwined components and contexts. These are partners' psychological and behavioural characteristics and their beliefs and assumptions about themselves and their relationships, but also the wider social context and the context of other close relationships that partners and their relationship exists in (Huston, 2000). All these elements are influenced and influence each other and "each spouse provides a context for the other" (Huston, 2000, p.314). PTSD disrupts this eco-system by changing partners' beliefs and assumptions about each other and their relationship. It enforces changes in partners' interactions with each other or with other people and changes in activities which they do with or without their partners.

The review of the literature presented in this section will highlight the importance of exploring of partners' experiences, as in the current study.

### **2.3.1. Partners' distress.**

Recognition of the negative impact of military personnel's PTSD on their relationships is mirrored in a rising number of studies. A literature review on 141 articles describing the impact of veteran's PTSD on the veteran's families (Galovski & Lyons, 2004) noted that several studies confirmed an association between PTSD and spouses' psychological distress. More recently, a literature review of 14 studies on spouses of military personnel that were involved in Iraq and Afghanistan conflicts, established that PTSD symptoms in military personnel were one of the main reasons for development of spouses' distress (De Burgh, White, Fear & Iversen, 2011). In another study, it was found that 70% of the Vietnam veterans with PTSD and their partners, compared to 30% of couples with no PTSD, reported clinically significant levels of relationship distress (Riggs, Byrne, Weathers



& Litz, 1998). Interestingly, in a meta-analytic review of 22 studies on the impact of PTSD on relationship quality and psychological distress of intimate partners, no association between PTSD and relationship quality was found, although an association between PTSD and partner psychological distress was identified (Lambert, Engh, Hasbun & Holzer, 2012). This can be explained by the fact that partners' quality of relationships might have been negatively affected shortly after being exposed to PTSD symptoms and that, with time, these negative effects transformed into psychological distress (Lambert et al., 2012). This would also suggest that the impact of PTSD on partners evolves over time and that stronger psychological distress, which can take the form of ST, might be experienced when traumatic incidents were further in the past. This can have direct consequences for partners of military veterans.

### **2.3.2 Relationship breakdown.**

Partners of military personnel diagnosed with PTSD are more likely to consider separation or divorce. This was found in two phenomenological studies on partners of Vietnam veterans (Lyons, 2001) and Israeli veterans (Dekel, Goldblatt, Keidar, Solomon & Polliack, 2005; Kimhi & Doron, 2013). However, in an assessment of research and analysis of marriage and divorces scale in the US military between 1996 and 2006 (Karney & Crown, 2007), it was established that marital divorce rates were not higher than they were in 1996. This is significant because US military personnel were engaged in difficult and dangerous Iraq and Afghanistan conflicts from 2003 onwards. Moreover, the authors found that deployment during marriage reduced a subsequent risk of marriage break-up. However, they acknowledged that this finding might be only short-term and not take into account marital satisfaction and the long term well-being of family members. Also, in a study on the impact of deployment to Iraq on romantic relationships in the UK military, no association between deployments and relationship breakdowns was found (Rowe, Murphy, Wessely & Fear,

2013). However, the latter findings should be treated with caution, because it presents only military personnel's opinions. If military personnel's partners had been included in the study, they may have stated that their relationships changed for worse.

### **2.3.3 Variables intrinsic to partners.**

Westerink & Giarratano (1999) conducted research with partners and children of Australian Vietnam veterans and found significantly higher levels of somatic symptoms, anxiety, depression and low self-esteem. Another study on Vietnam veterans established that both veterans and their spouses found veterans' anger the most difficult to deal, and relationship difficulties stemmed from manifestations of PTSD (Biddle, Elliott, Creamer, Forbes & Devilly, 2002). This finding was supported later in a study on Iranian wives of veterans with PTSD (Zarrabi et al., 2008). The study showed that partners had lower levels of marital and life satisfaction and self-esteem than women whose husbands did not suffer from PTSD. In another study, it was also concluded that wives of American veterans with PTSD experienced more problems with marital and family adjustments as compared to wives of veterans without PTSD (Jordan et al., 1992). Moreover, other studies found that wives of veterans felt lonely and had a sense of the loss of a previous life in practical terms, such as not doing some activities or jobs that they used to, but also in regards to their emotional well-being (Dekel et al., 2005; Kimhi & Doron, 2013). The wives in these studies were reported to be living in a state of constant worry about their partners' negative behaviours, and some had fears of them committing suicide. This worry is justifiable, because PTSD in military personnel is linked with suicide risk (Jakupcak et al., 2009; Lemaire & Graham, 2011), which is greater for veterans than for the general public (Rozanov & Carli, 2012). Moreover, partners were forced to take on more roles when living with their military partners with PTSD, such as that of main breadwinner, therapist, parent and caregiver (Lyons, 2001). Another study on Vietnam veterans and their partners revealed that partners had poorer

psychological adjustment in comparison to partners of veterans who did not have PTSD and high levels of ‘caregiver’s burden’ (Calhoun, Beckham & Bosworth, 2002). The latter is understood as experiencing physical, economical, psychological, emotional and social stresses because of caring for someone (Bastawrous, 2013).

#### **2.3.4 Impact of particular Posttraumatic Stress Disorder characteristics on relationships.**

The degree of severity of relationship distress positively correlates with the severity of veterans’ PTSD symptoms (Riggs et al., 1998). Moreover, most of the studies on the impact of PTSD among military personnel on their partners agree that specific PTSD characteristic, such as avoidance and hyperarousal, are more often associated with relationship satisfaction than others (Matsakis, 2004).

The PTSD characteristics of avoidance and numbing PTSD symptoms (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013) entail distancing themselves from others or avoiding expressing their feelings and thoughts. This has a significantly negative association with relationship satisfaction, as was found in various empirical studies (Campbell & Renshaw, 2013; Ray & Vanstone, 2009) but also in a review of research on the association between PTSD and relationship problems relating to deployments to Iraq and Afghanistan (Monson, Taft & Friedman, 2009). This comes as no surprise because emotional avoidance impairs military personnel’s emotional disclosure, which, consequently, affects communication and intimacy, both of which are highly important in relationships (Campbell & Renshaw, 2013). Moreover, it has been found in a study on one hundred dating couples that female partners are affected more negatively by veterans’ communication avoidance, especially in conflict situations (Afifi, Joseph & Aldeis, 2012).

The second symptom cluster negatively associated with relationship satisfaction is hyperarousal symptoms cluster (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013),

manifested by, for example, having angry outbursts, being irritable or anxious. The negative impact of this PTSD cluster was established in studies on Vietnam veterans (Evans, McHugh, Hopwood & Watt, 2003), peacekeepers (Ray & Vanstone, 2009) and military personnel deployed to Iraq and Afghanistan (Monson et al., 2009). PTSD hyperarousal symptoms are associated with aggression and hostility which, as shown in a meta-analysis of 31 studies on the association between PTSD and relationship problems (Taft, Watkins, Stafford, Street & Monson, 2011), are associated more with military-related PTSD than with non-military based PTSD. Extensive studies on Vietnam veterans and their partners (Jordan et al., 1992) and on military couples seeking therapy (Sherman, Sautter, Jackson, Lyons & Han, 2006) have found that military personnel with PTSD can be generally more aggressive with their families than those without PTSD. In another study on violent behaviour of military personnel serving in Iraq, it was found that 14.6% of those soldiers within the sample that were diagnosed with PTSD confessed to being physically aggressive (MacManus et al., 2012). These findings are important because they show that in households with military-related PTSD, there is likely to be a high prevalence of anger, hostility and aggression. This, consequently, can lead to domestic violence, which was found to be at a higher level in military families than in families where non-military-related PTSD was present (Taft et al., 2011).

### **2.3.5 Research on the British population.**

A comprehensive literature search revealed only two studies conducted on relationships of UK military personnel. The first study, on the effects of UK deployment to Iraq between 2003 and 2006 on military relationships, supported the claim that probable PTSD is associated with negative relationship change (Rowe et al., 2013). However, the association was quite weak, as it was only identified in 9.8% of relationships involving military personnel with PTSD. The second study, by Keeling (2014), acknowledged the

impact of military personnel's mental health conditions as a factor increasing the probability of relationship difficulties.

Despite the contributions of both studies, they had a very clear limitation in not including partners of military personnel in their participant samples. There appears to be a significant lack of research focusing on the experiences of UK partners of military personnel with PTSD, and how they are affected by and able to deal with those experiences. This is illustrated by the lack of such studies covered by a relatively recent literature review conducted by De Burgh et al. (2011). The review was conducted in the UK, but due to the lack of UK studies on spouses/partners of military personnel involved in Iraq and Afghanistan, it focused only on 14 US-based studies. This all suggests the need for more research in the area of military-related PTSD and relationships, especially in relation to UK study participants, which this study aims to contribute to by asking two research questions: 'what are partners' experiences of living with military partners with PTSD?' and 'how do partners cope with the impact of living with military partners with PTSD?'

## **2.4 SECONDARY TRAUMATIZATION**

Whilst research on relationship satisfaction and quality within military relationships has led to consideration of the psychosocial outcomes for romantic partners, this has been also interchangeably described as 'secondary traumatic stress' (STS) or 'secondary traumatization' (ST). This section will provide a description of this phenomenon, describing its components and relevant theoretical frameworks. It will be shown that ST is an important but controversial phenomenon. In recognition of this situation, this project will aim to contribute to discussions in the area of ST.

ST was first described by Figley as the 'cost of caring' (Figley, 1995) or as 'burden of care' by others (Campbell & Renshaw, 2013). ST is often misleadingly called compassion fatigue and vicarious traumatization (Jenkins & Baird, 2002), although there are important

differences between them. Compassion fatigue presents itself as emotional, psychological and social burnout (Figley, 1995) which might present itself in being less empathetic and caring (Lynch & Lobo, 2012). Vicarious traumatization is experienced as negative permanent alterations in core beliefs or “cognitive schema of self, other and the world” (Baird & Kracen, 2006, p.182). ST, on the other hand, is represented not only as emotional changes or transformations of ‘self’, but also by observable, PTSD-like symptoms, such as persistent avoidance or numbing, increased arousal and re-experiencing the traumatic event (Figley, 1995; Kanno, 2010). ST refers to emotional, psychological and physical impacts resulting from being affected by someone with PTSD, and it involves feelings of embarrassment, shame and guilt, but also self-blame for not being able to help their partners suffering with PTSD (Lev-Wiesel & Amir, 2001).

#### **2.4.1 Empirical studies.**

ST has mainly been described in relation to professionals, such as counsellors, social workers, aid workers and emergency workers, who work directly with people affected by trauma (Phelps, Lloyd, Creamer & Forbes, 2009; Elwood, Mott, Lohr & Galovski, 2011). Moreover, studies on the effects of parents’ PTSD suggested a trans-generational transmission of trauma from parents diagnosed with PTSD to their children (Dinshtein, Dekel & Polliack, 2011; Yehuda, Schmeidler, Giller, Siever & Binder-Brynes, 1998), which suggests that ST can result from sharing lives with a traumatised person rather than only helping them professionally. However, there has also been increased interest in studies on the ST phenomenon among various groups of partners. This interest is reflected in two literature reviews, by Galovski & Lyons (2004) and Baum (2014), which investigated altogether about 100 studies confirming the existence of ST. It is important to notice, though, that Galovski & Lyons (2004) used a broad description of ST as “any transmission of distress from someone who experienced a trauma to those around the traumatized individual”

(Galovski & Lyons, 2004, p.478). This understanding of ST, although providing insight into the different ways that trauma may affect a relationship and partners, does not allow for a detailed understanding of the secondary trauma. It also does not explain how ST would differ from psychological distress.

Studies on ST have been conducted on various populations of partners. This literature review focuses only on studies on military-related trauma, as well as one insightful study on spouses and children of Holocaust survivors, which gives a valuable insight into ST. This study on 90 couples, where one partner was a Holocaust child survivor with PTSD, confirmed that one third of the spouses suffered from full or partial ST, which was significantly associated with their partners' PTSD level (Lev-Wiesel & Amir, 2001). Another confirmation of ST came from a comparison study on veteran couples, childhood sexual abuse survivor couples and a control group (Nelson, 1998). This study established that partners of military-related trauma survivors have higher levels of ST than partners of childhood sexual abuse survivors. There might be several potential reasons for this finding relating to how ones' traumatic event is contextualised in partners' lives. It might be, for example, that partners are already negatively affected by their military partners' deployment or having difficulty adjusting to home life after their deployment. This might explain why, when partners of military personnel with PTSD become aware of the traumatic experiences, they do not appear to have as much emotional capacity to deal with this as do partners of childhood sexual abuse survivors.

A set of studies on PTSD related to the Bosnia-Herzegovina conflicts revealed surprisingly high levels of ST. Francickovic et al. (2007) study on 56 partners of veterans with PTSD of the Croatia war found that 39% of partners met criteria for ST. This significantly high level of ST might be potentially explained by the severity of veterans' conditions, as all of them had taken part in a year-long treatment programme (Francickovic et

al., 2007). Klaric et al. (2012) study also confirmed high levels of ST for partners of veterans with PTSD of the Bosnia & Herzegovina war, when compared with wives of veterans without a diagnosis of PTSD. 40.3 % of partners of veterans with PTSD had full PTSD and a further 58.4% had PTSD symptoms, but not full PTSD. Once again, the PTSD levels are staggeringly high even 12 years after the war. What is very interesting, though, is the fact that for the control group, partners of veterans without PTSD, 84.4% reported PTSD symptoms. In the light of the results from both studies it might be assumed that there are certain characteristics, for this particular population or the nature of the military conflict, which contributed to these findings. One possibility is that, in these two studies, partners might have been exposed to more traumatic experiences, compared with partners that participated in other studies, as they directly witnessed war trauma, which has not been controlled for.

Controlling for sources of partners' traumatic experiences is important, as discovered in a study on couples in which military partners were deployed in Iraq and Afghanistan conflicts after 2003 (Melvin, Gross, Hayat, Mowinski Jennings & Campbell, 2012). The study found the prevalence of ST at 34% but, when taking into account the presence of previous individual trauma, only 2%. This is a significant limitation of many studies on ST, which can lead to over-interpretation of ST prevalence, as it might be that partners' previous trauma is a contributor to their higher level of PTSD symptoms. Also, authors of a study on 45 American couples where male soldiers served in Iraq and Afghanistan operations after 2003 suggested that ST might be fuelled by more immediate exposure to war trauma through media coverage and contacts with soldiers who are physically stationed in Iraq or Afghanistan (Nelson Goff, Crow, Reisbig & Hamilton, 2007). They also discovered that soldiers' PTSD symptomology forecasts partners' individual trauma symptoms, especially avoidance symptoms. Also, a more recent study, on Dutch peacekeeper soldiers and their partners and parents, compared the impacts of living with peacekeepers with and without a



PTSD diagnosis (Dirkzwanger, Bramsen, Ader & van der Ploeng, 2005). Their study confirmed that partners of peacekeepers with a PTSD diagnosis experienced significantly more PTSD symptoms, somatic and sleeping problems, and had lower relationship satisfaction, than partners of those without a PTSD diagnosis.

Other studies on ST include a variety based on western populations of veterans' spouses, but also some in Middle Eastern countries, such as on Bedouin spouses (Caspi, et al., 2010) and Iranian spouses (Ahmadi, Azampoor-Afshar, Karami & Mokhitari, 2011). Caspi et al. (2010) found that wives had higher levels of PTSD than those of veterans without PTSD. However, ST was understood in this study more in terms of wives' caregiver burden and facing a new home situation, in which their husbands display unexplained behaviours to them. As they could not help their husbands, they consequently blamed themselves for this. A limitation of this study lies in the lack of clarification as to whether partners' previous exposure to traumatic experiences was controlled for in the study. In other words- it is not clear whether or not spouses with PTSD symptoms attributed their condition to their husbands' military-related PTSD or to some other pre-existing event. A study on Iranian spouses of veterans of the Iraq-Iran war, who were diagnosed with PTSD, found that all spouses had moderate or severe symptoms of ST (Ahmadi et al., 2011). The prevalence of ST in this study is surprisingly high, and explained by the authors by the cultural characteristics of the sample, where responsibilities to family and community are more important than people's own well-being. In Middle East and Islamic cultures, a spouse has a duty to care for her husband who "is considered to be injured for a divine purpose" (Ahmadi et al., 2011, p.641). As a result, high levels of ST might be explained by the existence of an 'empathy trap', where wives feel a particularly strong obligation to care for their partners, as this means that they are good wives (Ahmadi et al., 2011). In another study on Israeli spouses of former prisoners-of-war with PTSD, spouses had the highest level of PTSD symptoms, in

comparison to spouses of prisoners-of-war without PTSD, or spouses of veterans without PTSD (Dekel & Solomon, 2006).

#### **2.4.2 Development of secondary traumatization.**

ST is a complicated, disputed and controversial phenomenon even among its advocates. In recognition of this situation this project will contribute to the discussion in the areas of ST by asking whether ST exists and, if so, how it is represented.

##### ***2.4.2.1 Empathy and desire to help.***

The most common understanding is that ST can develop as a result of an emotional, empathetic response to a traumatised person who people care about and whom they want to help (Figley, 1995). Empathy is a fundamental element in ST development but this could be also said about, for example, compassion fatigue or vicarious traumatization, both of which develop as a result of experiencing emotional pain of the person with whom one is in an empathetic relationship (Lynch & Lobo, 2012; Trippany, White Kress & Wilcoxon, 2004). Also, in all the above mentioned phenomena, empathy evokes desire to help traumatized partners and to understand their emotional struggles and pain through identifying with them. In ST empathy has even a more profound impact as it leads also to internalizing the traumatized person's trauma symptoms and taking them as their own (Goff & Smith, 2005) which might result in re-living their traumatized partners' pain and developing certain trauma-related behaviours. This suggests significant emotional investment of people living with and trying to help traumatised partners, which over time can lead to 'empathetic burnout'. 'Empathetic burnout' is a particular type of burnout and it refers to significantly diminishing levels of empathy rather than, as in burnout per se - to general psychological stress stemming from functioning in demanding and difficult environments (Lynch & Lobo, 2012). 'Empathetic burnout might take place when, despite best efforts in understanding and

helping traumatised family members, partners' emotional investment might be not appreciated or even acknowledged (Lev-Wiesel & Amir, 2001). Partners might also feel disheartened by lack of improvement in regards to their traumatized partners' health. As a result, ST is quite distinct from compassion fatigue or vicarious traumatization. Empathy in ST might also lead to loss of hope in things getting better and feelings of helplessness.

Despite a prominent impact of empathy in development of ST, Dekel & Monson (2010) claimed that because there are no established mechanisms for developing empathy, there is no empirical support for the phenomenon of ST. This suggestion can be, however, challenged with Figley's Trauma Transmission Model (Figley, 1995). The model contains a description of how empathetic ability to notice others' pain leads to 'emotional contagion' (experiencing feelings of traumatized person) and 'empathetic concern' (motivation to help traumatized person) which then can be transferred into 'empathic response'. The model does not take into account, though, reasons for development of empathy which might stem from a sense of responsibility for partner's well-being stemming from, for example, cultural contexts (Ahmadi, et al., 2011).

#### ***2.4.2.2 Disclosure.***

Another important element of ST development is learning about traumatic experiences experienced by those that people are close to and care about, rather than through direct exposure (Figley, 1995). This assumption appears, however, to contradict the fact that marital communication is important and its quality is linked with intimate relationship satisfaction (Afifi et al., 2012; Hinojosa, Hinojosa & Hognas, 2012). However, this may be explained in that while emotional disclosure has a positive effect on partners and their relationships, factual disclosure can have a negative one (Campbell & Renshaw, 2013). This claim might be oversimplified as these studies did not take into the account the quality of the

relationships and communication between the partners before and after military personnel's homecoming. It might be that the couples with poor relationships struggle with open communication and emotional closeness, which makes them emotionally unprepared for disclosure of traumatic events. When this disclosure takes place, therefore, the impact on partners can be traumatizing. On the other hand, if partners have a good quality of relationship with open communication, any forms of disclosure should enhance their positive communication, as was confirmed, to certain extent, by a study on 10 couples in which one partner experienced a traumatic event (Nelson Goff et al., 2006). This would not then lead to ST development because partners would work things through and would seek support for their struggles and support each other. Moreover, findings from another study on the association between self-disclosure and marital satisfaction suggested that the most damaging triggers for marital satisfaction were low quality and quantity of disclosure (Schumm, Barnes, Bollman, Jurich & Bugaighis, 1986). The severity of partners' traumatic experiences might be also important for ST development, since it is natural to assume that there are some events more traumatic and distressing than others.

The assumption that learning about partners' traumatic experiences leads to ST suggests that, where partners of military personnel and veterans have developed ST, their traumatised partners must have talked to them about their traumatic experiences. However, many soldiers exhibit emotional numbing, resulting from their PTSD, which prevents them from emotional disclosure (Campbell & Renshaw, 2013; Balderrama-Durbin et al., 2013). Cultural differences may complicate matters even more. For example, Caspi et al. (2010) found that partners' ST symptoms and psychological distress were not related to army personnel partners' disclosure because emotional disclosure in Bedouin couples is simply not tolerable. In another study, it was confirmed that spouses had lower levels of marital quality, even if they were not told by their partners about traumatic events, in comparison to spouses

whose partners did not have PTSD (Lev-Wiesel & Amir, 2001). The authors explained that it was, in fact a combination of knowledge about a traumatic experience and being exposed to partners' PTSD symptomology which was responsible for their relationship distress.

#### ***2.4.2.3 Ongoing exposure to military partners' Posttraumatic Stress Disorder symptoms.***

Findings from the studies described above suggest that being told about a traumatic event is not necessarily a decisive reason for developing ST. The same seems to apply to empathy, which might not only lead to an emotional desire to try to help military partners. Empathy might also be perceived as a source of responsibility for their military partners, and lead to making sense out of their military partners' experiences by internalizing their feelings. It seems then that there can be another explanation for ST development, which will also be explored in this current project. It might be that being exposed to ongoing psychological distress of caring for and witnessing military personnel's PTSD symptoms or behaviours stemming from their condition becomes a chronic stressor and, over time, leads to experiencing symptoms of traumatization by that person (Monson et al., 2009; Lev-Wiesel & Amir, 2001). This was also suggested in certain studies. In one of them, it was suggested that ST results from an internalization process of experiences and feelings of the traumatised person. This requires empathy and emotional connection with the traumatised person, but also being in the presence of that person for some time (Nelson, 1998). Being exposed to PTSD symptoms on daily basis was also confirmed to be a strong factor in developing ST in a study on Dutch peacekeeper soldiers and their partners and parents (Dirkzwanger et al., 2005). Interestingly, there was no significant difference in terms of the negative impact on peacekeepers' parents, who, although caring and empathizing with them, were not exposed to their suffering on daily basis. This confirms that living with a person diagnosed with PTSD

might be a stronger factor in developing ST than only caring about or wanting to help that person.

This chronic stress might also stem from facing rejection and even aggression, instead of receiving appreciation for empathic offers of help (Lev-Wiesel & Amir, 2001). In fact, military personnel's aggressiveness and violence might be a particularly important factor, as it was found that physical abuse positively correlates with PTSD symptoms of the victims of violence (Elwood & Williams 2007; Scott & Babcock, 2010). Moreover, being confronted with their partners' hostile reactions might lead them to feel trapped between their sense of responsibility for their partners and feeling hurt, misunderstood and not appreciated.

### **2.4.3 CONTROVERSIES**

The existence of ST was challenged by the earlier explained phenomenon of 'empathy trap', (Ahmadi et al., 2011). Some authors also argue that ST studies were largely misinterpreted which was shown in the study on 190 wives of American service personnel it was found that, among wives who exhibited PTSD symptoms, only 12.9% attributed their symptoms solely to their husbands' military experience (Renshaw et al., 2011). However, the study actually supported the existence of ST, although in fewer participants than expected. It also highlighted that it is natural that not everyone will develop ST through living with someone with PTSD, because not everyone develops PTSD after experiencing a traumatic event. Moreover, participants who attributed their symptoms solely or partially to their husbands' military experiences had a greater overlap between responses on the PCL-C and the general psychological measure, compared to wives who attributed their symptoms to other experiences. This suggests that the impact of their husbands' experiences created a strong association between PTSD symptoms and partners' psychological well-being.

However, husbands who reported domestic violence were excluded from the study which may have biased results as their wives could have been at even higher risk of ST.

Renshaw, et al., (2011) described wives' experiences in their study as a type of psychological distress. However, this term seems simplistic as it does not take into account multiple layers of ST, which are expressed through emotional, cognitive and behavioural symptoms of distress which mimic PTSD-like symptoms. It also does not take account of the fact that the severity and duration of PTSD symptoms forecasts the severity of spousal ST, as found in, for example, a study conducted by Ahmadi et al. (2011). Also, perceiving ST as a transmission of distress from a traumatized person to another (Galovski & Lyons, 2004) does not explain how ST would be different to psychological distress, an issue which this current study aims to explain.

Another controversial issue around ST is the fact that it has not been recognised as an autonomous condition in the *International Classification of Diseases* (10<sup>th</sup> ed.; *ICD10*, World Health Organisation, 1990), the *DSM-IV* (4<sup>th</sup> ed.; *DSM-IV*, American Psychiatric Association, 1994) or the *DSM-5* (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013).

Paradoxically, though, the phenomenon is recognised as a legitimate condition that affects professionals working with trauma. Interestingly, *DSM-5* recognises that PTSD can be acquired by learning about the traumatic event which happened to someone close to us such as a family member, which validates the way in which ST is hypothesised to develop. In fact, the *DSM-5* description of PTSD suggests that ST might be perceived as a form of PTSD, which provides interesting scope for professional judgment of those diagnosing partners of military personnel. However, equating ST with PTSD would not explain the fact that spouses might display PTSD symptoms without learning about the precise details of traumatic experiences of their military partners. It would also not validate experiences of those partners who might exhibit some PTSD symptoms but not all of them.

#### **2.4.4 THEORETICAL EXPLANATIONS FOR THE DEVELOPMENT OF SECONDARY TRAUMATIZATION**

The limited understanding of ST development stems from a lack of empirically evaluated models explaining ST development. However, there are a few theories rooted in psychology which are useful in shedding light on potential reasons for partners being affected by military personnel's PTSD. According to Valent's (1995) model of ST development, ST develops as a result of a failure of personal survival strategies and biological, psychological and social responses which, although functioning well before a traumatic situation, become unsuccessful. Although the theory does not take account of fundamental assumptions of ST, such as empathy and care for people affected by traumatic incidents (Figley, 1995), it recognises individual factors that make people more prone to ST development.

Other theories suggest that partners' perceptions of military personnel's and veterans' severity of PTSD symptoms, as well as attributions of their PTSD symptoms, influence partners' psychological symptoms and levels of marital satisfaction. In studies of 465 spouses of Vietnam veterans (Renshaw, Rodebaugh & Rodrigues, 2010) and on National Guard servicemen who were deployed in Iraq and their spouses (Reneshaw, Rodrigues & Jones, 2008), it was discovered that spouses' perceptions of the severity of soldiers' and veterans' symptoms of PTSD were positively associated with spouses' marital and psychological distress levels. This effect was the strongest when partners perceived their military partners as having high levels of PTSD symptoms, even though military personnel perceived their own symptoms as low. Moreover, partners experience less marital distress when they understand that their military partners' behaviour results from an external factor, as compared to when they cannot find external reasons for their behaviour. This can be explained by the attributional model (Renshaw, Allen, Carter, Markman & Stanley, 2014), which is supported with findings from a study conducted by Renshaw & Caska (2012) on partners of Iraq and



Vietnam veterans. This study explains that partners were not much affected by their military partners re-experiencing symptoms because these symptoms were clearly linked with a traumatic incident and PTSD behaviour. However, they were more affected by withdrawal/numbing symptoms, which were not PTSD-specific, making it more difficult to distinguish whether these symptoms resulted from a traumatic incident or if they were family and relationship-related.

The influence of partners' cognitions can be linked with the cognitive-behavioural interpersonal model of PTSD (Monson et al., 2009), which explains how PTSD is associated with adult close relationships. This model explains how cognitions, behaviours and emotions interrelate within each partner, which has, consequently, an effect on the relationship and on each partner individually (Monson et al., 2009). The model has obvious similarities with cognitive-behaviour couple's therapy (Schroder, 1991) but it sees PTSD as the trigger for maladaptive patterns of partners' interactions. Moreover, it takes into account both romantic and non-romantic close relationships. The model also considers the significant changes to emotional responses of the traumatised person who might be now characterised by anxiety, shame, guilt, anger, grief but also emotional numbness (Monson et al., 2009). It also takes into account PTSD symptoms which relate to a traumatised person's behaviour and their effects on others, as well as other people's reactions to it.

The cognitive-behavioural interpersonal model of PTSD explains how partners' might, in fact, maintain avoidant behaviour of someone with PTSD and, for instance, increase their hyperarousal and aggressive behaviour (Monson et al., 2009). Families often avoid challenging or trying to solve the traumatised person's negative behaviour, fearing it would escalate their behaviour and result in bigger distress. They think they are helping them and the family but, in fact, they maintain PTSD symptoms, which leads to a decrease in partners' communication, problem solving capacity and relationship distress. Also, poor

communication could stop military personnel from disclosure of a traumatic event, which is essential in cognitive and emotional processing of traumatic incidents (Balderrama-Durbin, et al., 2013). Although this model of PTSD gives an insight into how certain PTSD symptoms can explain mechanisms of relationship distress development, the empirical studies focused on investigating only particular mechanisms of the model, for example, how certain malfunctioning cognitions impact the relationship (Dekel & Monson, 2010). Moreover, the model also does not focus on the phenomenon of ST but emotional distress in the relationship and the family.

The only theory that tries to explain ST by focusing on the reciprocal transmission of traumatic stress in a relationship is Couple Adaptation to Traumatic Stress (CATS) model (Nelson Goff & Smith, 2005). The model focuses on circular individual primary and secondary impacts of trauma, but also on how trauma impacts on interpersonal relationships within the couple subsystem. It suggests that the way the couple and the partners deal with traumatic stress depends on three factors continuously interacting within and between the partners. They are: acute and chronic individual levels of functioning, predisposing factors and resources and couple functioning (Nelson Goff & Smith, 2005). Acute and chronic individual levels of functioning refer to primary and secondary trauma symptoms. Primary trauma symptoms are about how partners are affected directly by a traumatic incident. Secondary trauma symptoms are about being affected by a primary trauma survivor's behaviours and emotional responses, which arise from exposure to the traumatic incident, but may also be caused by seeing how trauma survivors are affected by the incident. Predisposing factors relate to partners' pre-existing vulnerabilities in developing and dealing with primary or secondary trauma, such as young age, previous trauma or mental health conditions but also insecure attachment, which is incorporated as an element of a couple functioning. Resources relate to practical (such as money) and emotional strengths (such as social support). Couple

functioning comprises several components, such as attachment, empathy and identification, support, nurturance, role disruption, communication (Nelson Goff & Smith, 2005). However, it is the mechanisms of systemic traumatic stress in couples suggested by these authors, which makes the CATS model the most comprehensive in describing the creation and maintenance of ST.

The CATS model, although not empirically validated as a whole model (Nelson Goff & Smith, 2005), is extremely relevant to ST as it points out reciprocal rather than linear relationships between primary and secondary traumatization. It appreciates that development of ST depends on both individual and couple-related factors and that “romantic relationships and PTSD symptoms have the potential to negatively influence one another, each worsening the other over time” (Ray & Vanstone, 2009, p. 839). This can be potentially explained by a traumatic experience rupturing the ‘secure base’ that partners provide for each other (Basham, 2008). If one partner becomes traumatized and develops PTSD, he/she stops being a source of comfort and security for his/her partner in difficult situations. This has a negative impact on that partner, which might make it difficult, if not impossible, to remain a ‘secure base’ for the traumatized partner. Also, traumatic experience disrupts a process of ‘projective identification’ taking place in partners’ relationship. During this process, partners project onto each other unwanted or denied unconscious desires, wishes and needs which have not been fulfilled in earlier relationships, especially with primary caregivers (Scharff & Scharff, 2008). These are then introjected by partners and this process becomes a source of unconscious support for each other. After a traumatic incident, which evokes psychological and physical changes to a traumatized partner, continuation of this process in an existing form is impossible, resulting in a negative impact on both partners. They might even start perceiving their relationship as unsatisfactory, if not emotionally threatening (Hamilton, Nelson Goff, Crow & Reisbig, 2009).

The reciprocal character of PTSD and ST is highlighted also in family systems theory, which highlights the need of each family member to be understood in relation to other family members. According to this theory, family can become a source of strength and support for each other as an ‘emotional unit’ when joining their efforts together, creating a sense of ‘togetherness’ (MacKay, 2012). At the same time, family members might feel overwhelmed with the negative experiences of a traumatised family member, which can lead to evoking more anxieties for them, subsequently passed back to the traumatized family member. It might even contribute to ST development in them. Also, when non-traumatized family members are sensitive to others’ opinions and have a strong need for their approval and praise, they might feel distraught and anxious because of not being able to help the traumatised family member (MacKay, 2012). To make the situation even more complicated - when the same needs are held by the traumatised family member, this might make him/her more prone to be affected with his/her traumatic experiences (Kerr, 2000) and to develop PTSD as a result.

Unconscious needs and desires, as well as assumptions that people make about themselves and other family members are often at the centre of people’s predisposing vulnerabilities to being affected directly or indirectly with traumatic experiences. These vulnerabilities may stem from unresolved early relationships with primary caregivers. It is these first emotional relationships which are responsible for the development of particular types of attachment patterns, which shape expectations of oneself and others in relationships and “guide the individual’s contact with others in adulthood” (Elwood & Williams, 2007, p. 1191). Secure attachments lead to having positive views and expectations of oneself and, consequently, are a source of resilience and security (Muller, Kraftcheck & McLevin, 2004). This makes secure attachments helpful in dealing with traumatic experiences for primary and secondary trauma survivors. Insecure attachments are associated with negative

thoughts of self and others and are a source of maladaptive adult relationship patterns (Muller et al., 2004). They also increase people's vulnerability to different stressors, which makes them more prone to be negatively affected by traumatic experiences (Nicholls, Hulbert-Williams & Bramwell, 2014) and more likely to develop PTSD (Scott & Babcock, 2010) or ST. Also, if partners share insecure attachment patterns it is more difficult for them to work through the impact of a traumatic experience on their relationship and themselves individually. They would either deny existence of this impact (dismissing attachment pattern), or their need of constant comfort and dependency, created by adverse early experiences, would even make their dependence on one another stronger (preoccupied attachment pattern) (Basham, 2008).

The mechanisms of systemic traumatic stress in couples suggested by these theories makes the CATS model (Nelson Goff & Smith, 2005) the most transparent in describing the creation and maintenance of ST. This model could be used to explain partners' development of ST or maintenance of PTSD observed in earlier studies. For instance, in a study conducted by Nelson (1988), military partners' deployment affected the 'couple functioning', in particular couple's changing roles, stability and satisfaction. This had a negative, reciprocal impact on both partners, leading to them being more prone to developing PTSD and ST. Also the existence of predisposing factors in ST development, such as previous trauma, explained why partners with traumatic histories were more prone to exhibit ST (Klaric et al., 2012; Melvin et al., 2012). It is important to state that being more predisposed to experiencing ST does not change the fact that if they did not care for and empathise with their partners' with PTSD, they might have not developed ST in the first place. Instead, being a witness to their partners' suffering they might also re-experience their own traumatic experiences. Another predisposing factor, which was crucial in ST development in Iranian spouses (Ahmadi et al., 2011), was the lack of predisposing support available to wives in this particular culture.

Although individual elements of the CATS model are useful in understanding what the main factors in ST development might be, it is important to see these factors in a more holistic and comprehensive way, which the CATS model allows for. It combines, in an eclectic way different psychological approaches. For example, the cognitive-behaviour interpersonal model of PTSD can be used to explain different emotional, behaviour, cognitive and biological symptoms of PTSD allowing understanding of partners' immediate behaviours and moods. Psychodynamic theories, such as attachment approach or object relations, can explain how predisposing factors to trauma development, such as negative early childhood experiences, influence partners' responses to primary trauma and potential development of secondary trauma. Drawing on life course perspective or systemic theories, the way partners negotiate their experiences in the context of their relationships and family systems, as well as being embedded within particular historical and social-cultural environmental contexts (Sugarman, 2001), helps or hinders the way that they cope with a traumatic incident. Certain contexts are more important than others at different developmental stages which are highlighted in life course development theories and might explain, for instance, importance of social support being a protective factor against the development of PTSD (Ozbay et al., 2007).

The CATS model will be referred to again in the discussion of findings (Chapter Four). Moreover, the attributional model will also be drawn on in the research project, as it is believed that this model presents a good explanation of cognitive misinterpretations, which lead to and maintain partners' stress.

#### **2.4.5 IMPORTANCE OF RESEARCH ON SECONDARY TRAUMATIZATION**

Most of the available research about the quality of relationships, when one partner has PTSD, seems to have been conducted from a military personnel's stance, exploring how the quality of the romantic relationship and family support can impact on their PTSD and recovery. This particular focus in the studies is dictated by findings that positive romantic relationships are a source of social support, which positively influences soldiers' mental health (Jones, et al., 2014). Also, positive relationships make military partners keener to initiate PTSD treatment and to continue therapy, compared with military partners who do not feel satisfied in their relationships (Buchanan, Kemppainen, Smith, MacKain, & Wilson Cox, 2011). However, by focusing on how to use relationship support for the benefits of military personnel, there is no recognition given to the fact that military personnel's PTSD might also make partners victims of their mental health condition. This leads to family members' well-being and needs being overlooked and misunderstood, which means that they do not receive the appropriate practical and psychological support.

As not enough attention is focused on solely understanding the experiences of families and partners living with those who experience PTSD (Dekel et al., 2005; Ray & Vanstone, 2009), this became the central focus of this study. This is reflected in the first two research questions, about partners' experiences and ways of coping with living with military partners who were diagnosed with PTSD. Moreover, the relevance of these research questions is even clearer in the light of findings which suggest that PTSD prevalence increases with time (Thomas et al., 2010; Fear et al., 2010). As a result, even if currently serving military personnel or recent veterans do not report PTSD symptoms, it is possible that they will develop into delayed-onset PTSD (Schnur et al., 2003; Utzon-Frank et al., 2014). This means that more partners of military personnel could be affected by their trauma in the near future.

The third research question about the potential existence of ST, and how it is represented in these relationships, is also very relevant, as research in this area has significant gaps. The consequence of these gaps is that there is conflicting and incomplete knowledge about ST, and some researchers even question its existence (Renshaw et al., 2011). There is not one agreed conceptualization of ST. For example, ST was described as ‘empathy trap’, (Ahmadi et al., 2011), ‘any transmission of distress from a traumatized person to another’ (Galovski & Lyons, 2004) or ‘psychological distress’ (Renshaw, et al., 2011). The research question about ST gives an opportunity to explore the extent of the impact of primary trauma on partners. This topic was also explored in some studies on partners’ experiences (for example: Dekel et al., 2005; Kimhi & Doron, 2013) and also in research on transgenerational trauma where it was found that traumatic experiences can be transferred from one generation to another (Dinshtein et al, 2011; Yehuda et al., 1998).

The research questions for this current study focus only on British population because, to the best knowledge of the researcher, there have been only two studies conducted on relationships of UK military personnel, by Rowe et al. (2013) and Keeling (2014) and none on ST. Also, there is a significant lack of qualitative studies in the area of ST, which could be an invaluable source of in - depth understanding of individual experiences and what it means to live with someone who was diagnosed with PTSD. Moreover, it could help to understand ST phenomenon as well as its development and maintenance.

In this qualitative project on UK partners living with military partners with PTSD, various research questions about the quality of partners’ lives, how they have been affected by their military partners’ PTSD and how they have coped with it are being addressed. This study will contribute to psychological research, as well as raising awareness of the ST phenomenon. The latter could then be reflected in raised awareness of professionals, which might result in giving the same recognition to the ST experiences of family members as has



been given to those of trauma victims. It might also inform future clinical and social interventions in the area of ST.

## **CHAPTER 3 - METHODOLOGY**

Interpretative Phenomenological Analysis (IPA), a qualitative research method, will be applied in this study. In this chapter, the rationale for using a qualitative approach will first be explained. Following this an explanation of IPA will be provided. The PTSD Checklist for Civilians (the PCL-C), the screening tool used in the study to identify participants with the highest probability of PTSD, will be described. It is important to notice that, despite using the psychometric method as a screening tool, the methodology in the study is qualitative methodology, which can be both an experimental and experiential scientific discipline. Finally, the method for the present study will be outlined.

### **3.1 QUALITATIVE METHODOLOGY**

Qualitative methodology focuses in depth on participants' subjective experiences, appreciating participants' uniqueness and individuality, which resonates well with the counselling psychologists' humanistic ethos (Rizq & Target, 2010). The strength of qualitative methodology is that it investigates participants' experiences in their natural environment and that it tends to be participant-led rather than researcher-led. It strives to find deeper, more complex explanations of particular experiences and phenomena. It also postulates that absolute truths are not possible to obtain due to different levels of subjectivity present, in regards to participants' experiences and between the researchers and participants (Morrow, 2007). Moreover, the focus of qualitative research is on how and what meaning is being made by participants rather than on finding causal relationships between variables (Willig, 2001). This allows for exploring phenomena which are difficult to investigate using quantitative methods, where available research is somehow incomplete and contradictory or about which little is known (Morrow, 2007). As the latter seems to be the case with UK

partners' experiences of living with military partners with PTSD, using qualitative methodology in this study seemed like a suitable choice.

Qualitative methodology also opens the possibility of combining the role of a scientist systematically investigating a certain phenomenon with the role of a reflective practitioner. The level of reflectivity is especially relevant for counselling psychology, which has at its heart continuous development of self-reflection and self-awareness (Rizq & Target, 2010). Moreover, Morrow (2007) suggested that counselling psychologists might find qualitative methodology more congruent with the essence of their therapeutic work, which is based on collaborative creation of the meaning and its understanding using mainly narratives.

### **3.2 INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS**

Interpretative phenomenological analysis (IPA) is a psychology-based qualitative method which is used to study people's life experiences, which are embodied in particular contexts, and how they make sense of them, from the position of the researcher (Larkin, Eatough & Osborn, 2011). As a result, IPA helps to explore in the study the depth of participants' individual experiences in their particular contexts of being in relationships with military partners diagnosed with PTSD.

#### **3.2.1 PHILOSOPHY AND EPISTEMOLOGY**

IPA can be seen as a subdivision of the interpretivist - constructivist paradigm, where reality is represented by relativist ontology, which means that there are no absolute truths or realities (Morrow, 2007). Instead, the realities and meanings are co-constructed by participants and researchers involved in the research, which means that IPA epistemology is transactional and subjectivist (Morrow, 2007). According to transactional and subjectivist epistemology, participants and researchers are linked by bringing to research certain

knowledge each of them has of himself/herself and the world in which they are all embodied. IPA is rooted in three areas of philosophy of knowledge: phenomenology, hermeneutics and idiographic (Smith, Flowers & Larkin, 2009). Exploration of these philosophies is essential in order to understand how to study and interpret peoples' experiences. It also enables us to comprehend the way in which IPA is dedicated to paying full attention to the individuality of people's experiences, which are taking place in the world outside.

Phenomenology is a philosophical approach which focuses on different aspects of peoples' lived experiences in the purest forms, the way they really are and what constitutes them (Smith, 2008). As a result, it informs the ways of exploration of peoples' experiences and their understandings, which should be examined "in the way that it occurs, and in its own terms" (Smith et al., 2009, p.12). In order to do that, researchers need to be deliberately reflective when observing people's lived experiences and remember that people are embedded in a variety of contexts, which they share, overlap or even remain in reciprocal relations with. As a result, participants are always seen as 'being-in-the world' and 'people-in-context' (Larkin et al., 2011). Therefore, people affect and are affected by different environments they exist in and they create and constantly make interpretations of their experiences in relation to those environments. Awareness of this phenomenological intersubjectivity is essential in phenomenological investigation in psychology, as it enables richer interpretation of peoples' 'lived experiences' and their meanings that are embodied in the world outside (Larkin et al., 2011).

IPA involves interpretation of participants' experiences and because of that it is informed by hermeneutics, the theory of interpretation. Interpretation of data by IPA researchers is described as 'double hermeneutics' (Smith et al., 2009) which is a process in which researchers try to understand participants' ways of making sense of their experiences who, at the same time, try to make sense out of the experiences they talk about. This suggests

that researchers have an additional role to play, as they become participants themselves by taking part in meaning creating processes and making sense out of participants' experiences, which become a part of the world they live in. Double hermeneutics refers also to merging a hermeneutic of 'empathy' together with hermeneutics of 'questioning', which means that the IPA interpretation should encompass two positions of the researcher, as an insider and an outsider of participants' experiences (Smith et al., 2009). The former refers to experiencing, through empathy, participants' experiences as their own, while the latter refers to questioning participants' experiences from different perspectives. Those multiple levels of analysis enable deeper engagement with the data.

IPA researchers interpret participants' experiences at perceptual and analytical levels (Smith et al. 2009). The former refers to the exploration of things that are being said and which, in the process of expressing them, present themselves with new, direct and hidden meanings. The analytical level of interpretation refers to focusing on the discourse produced by participants. These intertwined levels of interpretation aim to offer insights which "exceed and subsume the *explicit* claims of our participants" (Smith et al., 2009, p.23). This does not mean, though, that researchers' interpretations are truer than participants' interpretations. It only suggests that researchers can offer new perspectives on what participants have expressed, which are unavailable to them otherwise.

'Double hermeneutics' is set in the dynamic and non-linear 'hermeneutic cycle' in which the researcher's life story interacts with his/her encounter with participants (Smith et al., 2009). The researchers' life story is full of past and ongoing experiences, which leads to preconceptions and assumptions that influence their ability to understand participants' subjective experiences to their fullest extent. As a result, philosophers like Husserl, urged researchers to develop the ability to 'bracket off' part of their own perceptions in phenomenological research and Heidegger suggested at least being mindful of them prior to

any encounter with participants (Smith et al., 2009). Gadamer, on the other hand, argued that researchers' preconceptions can become fully acknowledged only when the interpretation has already started taking place, which makes bracketing them off prior to conducting the research impossible (Smith, et al., 2009).

'Bracketing' has been a controversial concept in phenomenological research because it has been interpreted as a reduction or even extraction of a researcher's individuality (Larkin et al., 2011). However, this can also be viewed as researchers being self-reflexive and self-aware enough to notice, explore and challenge pre-conceptions and pre-assumptions present at different stages of the research process. These pre-conceptions and pre-assumptions are pre-existing, but they also change as a result of hearing participants' stories, and with every interpretation of the data (Smith et al., 2009). 'Bracketing' is essential in order to allow researchers more depth-engagement in the collaborative process of the researcher making sense out of participants' meaning making, where they give full attention to participants' stories rather than being pre-occupied by their own (Smith et al., 2009).

IPA is an idiographic form of enquiry, which means that it focuses on 'the particular' by giving full attention to details of certain lived experiences and how specific participants understand and manage them in particular contexts (Smith et al., 2009). This implies concentrating only on a small sample of participants, as the aim of the phenomenological investigation is to look as closely as possible at those individual experiences and to appreciate them for what they are (Hayes, 2000). This, however, does not mean that, even in one-case studies, full attention is given only to the experiences of that particular person. Although his/her experiences are unique and individual, they are also "a worldly and relational phenomenon" (Smith et al., 2009, p.29). As a result, after focusing on participants' unique experiences, the IPA researcher is able to reflect on similarities and differences between certain experiences of individual participants and, most importantly, how they understand and

manage them. This is possible because the sample of participants in IPA research is small but homogeneous, allowing for a more straightforward comparison between experiences.

Participants are expected to relate to one type of shared experience which, in the current study, was the experience of living with a military partner who has PTSD.

### **3.2.2 STRENGTHS OF INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS**

IPA makes a unique contribution to research in psychology and clinical practice of researchers by focusing on ‘the particular’. It does not see, as in the nomothetic quantitative approach, that the behaviour of an individual “is the outcome of laws that apply to all, and the aim of science is to reveal these general laws” (Ashworth, 2008, p.14). As a result, instead of discussing probabilities, averages and focusing on statistics, it concentrates on understanding participants’ experiences and interpretations of them which are created in their natural environments, hence being more authentic. It is the individual that matters the most in IPA rather than, as in discourse analysis, only the function of the discourse people use to create their realities (Willig, 2008) or recognizing, analysing, and recording patterns within data in thematic analysis (Braun & Clarke, 2006).

Because of the phenomenological stance of IPA, IPA develops richer descriptions of individual and subjective participants’ experiences and how they make sense of them, which are the focus of the current study. This is even deepened by the researcher’s awareness of phenomenological intersubjectivity (Larkin et al., 2011) which is reflected in, for example, the researcher providing participants’ short descriptions (Confidential Attachment 1) which contextualise participants’ experiences and expands the researcher’s interpretations of them. Because of the phenomenological stance of IPA the researcher is able to ask open research questions, which allows for the provision of rich data of phenomena and experiences of

particular groups of participants which have either never been explored or about which there is not substantial knowledge (Smith et al., 2009). This is particularly important in the current research which focuses on a participants group that has not been, to the best knowledge of the researcher, the main interest of even one UK research study and on ST, which is not a well-researched phenomenon.

Although IPA might not be so well-suited to theory-building, as with quantitative research, IPA can facilitate the making of general claims as “it locates them in the particular, and hence develops them more cautiously” (Smith et al., 2009, p.29). Moreover, the transferability of findings in IPA studies can suggest their application to wider populations (Smith et al., 2009). This can have direct implications for more informed clinical work with clients by including in partners’ clinical formulations and interventions psychological impact of living with military partners with PTSD and experiencing, as a result, potential ST. This might also potentially ‘unsilence’ a societal group (Davis, Ward & Storm, 2011) of military partners.

Another strength of IPA stems from the fact that it is not only the collection of data that is important in IPA but the research process itself. This process is a composition of participants’ experiences and meanings of them, but also the researcher’s interpretations made in the course of ‘double hermeneutics’ (Smith et al, 2009). That is why semi-structured interviews are such a well-suited research method in IPA, as they allow researchers and participants to co-construct at various conscious and unconscious levels certain understandings of participants’ experiences (Yeh & Inman, 2007). That is the reason why researcher does not need to have any knowledge of participants’ chronological life events, which led them to their current experiences, as required in narrative psychology (Murray, 2008). Phenomenological in-depth engagement with participants is enough to give researcher an insight as to how their past shaped their present experiences. In contrast to narrative



research, this can be achieved in IPA within a single in-depth interview. Also, semi-structured interview is not only a way of collecting the data but it is the process in which this is created and through which participants' experiences are validated, appreciated and given full attention, which is a significant advantage of IPA over quantitative studies.

Collaborative elements distinguish IPA from other qualitative methods. The researcher is an integral part of the research by being in a constant engagement not only with participants' data but with their own preconceptions and pre-assumptions, which they make an effort to be in tune with and to 'bracket-off' in the research process. This unique engagement with and within the research is unique and requires researchers to be self-reflective and use empathy and unconditional acceptance when interacting with participants. This made IPA a natural choice for the researcher, who has a background in counselling and who is a Counselling Psychologist trainee.

Additional strength of IPA is the fact that it can be conducted on a small number of participants, it allows for conducting the study on 'difficult to recruit' populations. This seems to have been the case in this particular study, due to difficulties with advertising the study and a potential lack of recognition of the issues even within participants themselves. Also, due to concentrating on small participant samples, IPA brings a significant depth of data and analysis.

### **3.3 SCREENING TOOL**

The PCL-C, a self-report questionnaire, was used in the current study as a screening tool (Appendix 1). The PCL-C is a research instrument widely used - for people in high-risk occupations who are likely to develop PTSD (Bliese et al., 2008) and can be used in clinical settings, but only as an additional source of information and cannot replace a comprehensive diagnosis of PTSD. It is also widely used in research exploring ST as, to the best knowledge

of the researcher, there are no ST screening tools designed for non-professionals working with traumatized people. Despite the fact that the PCL-C is not specifically designed for measuring ST, it allows the identification of people who have “a high probability of a disorder and are likely to benefit from a thorough clinical evaluation” (McDonald & Calhoun, 2010, p.977).

The PCL-C measures 17 symptoms of PTSD, based on the criteria of *DSM-IV* (4<sup>th</sup> ed.; *DSM-IV*, American Psychiatric Association, 1994). The PCL-C has a “high level of diagnostic accuracy” (Forbes, Creamer & Biddle, 2001, p.978) and comprises 17 questions, with a self-rating scale between 1 (“not at all”) and 5 (“extremely”) for each of them. The 17 questions refer only to PTSD symptoms from three symptom clusters: intrusive recollections (criterion B), avoidant/numbing (criterion C) and hyper-arousal symptoms (criterion D) (McDonald & Calhoun, 2010). This means that the PCL does not assess traumatic events (criterion A), their duration (criterion D) and functional significance criteria of possible trauma (criterion F). The fact that the PCL-C can be applied to any traumatic experience might lead to “a higher rate of false positives” (McDonald & Calhoun, 2010, p.983). At the same time, however, it is recognised that the PCL-C is reliable and efficient (Orsillo, 2001) and is widely used in screening and monitoring of symptomatic changes for PTSD, mostly in large research studies, such as with military populations (Bliese et al., 2008).

Possible PCL-C scores range between 17 and 85. Previous research has shown that a range of cut-off scores from 28 (Lang, Laffaye, SatzDresselhaus, & Stein, 2003) to 60 (Keen, Kutter, Niles & Krinsley, 2008) have been applied to the PCL-C self-report, in order to indicate the likely presence of PTSD symptoms. The wide range of cut-off scores applied in these studies has depended on the aims of the checklist (whether used for screening or for diagnosis, for example), the setting and population (Bliese et al., 2008). Lower cut-off scores are generally used for civilians, primary care patients and for screening purposes. Using a

cut-off score method for scoring participants' answers on the PCL means that the scores are scrutinized only in terms of how high they are, without commenting on whether the participants obtain all symptom criteria expected in the *DSM-IV* (4<sup>th</sup> ed.; *DSM-IV*, American Psychiatric Association, 1994).

A minimum cut-off point of 30 was selected for this study. This is one of the lowest cut-off scores available which has been validated in previous studies, in terms of its specificity and sensitivity (Bliese et al., 2008; Walker, Newman, Dobie, Ciechanowski & Katon, 2002). The selection of a relatively low cut-off score was necessary to ensure a sufficient number of study participants, given time and resource constraints. Moreover, participants were recruited not on the basis of them having PTSD but PTSD-like symptoms, suggesting that they were more likely to be experiencing ST - a possibility which would be further explored in semi-structured interviews. As a result, it would be expected that participants would present their symptoms at a lower intensity level than one might expect for full PTSD.

In this study the PCL-C that is used draws on *DSM-IV* (4<sup>th</sup> ed.; *DSM-IV*, American Psychiatric Association, 1994). It is important to note, however, that with the introduction of a fifth version of the *DSM* (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013) a new version of PTSD Checklist was created – the PCL-5 (Weathers et al., 2013). The PCL-5 seems to be an even more reliable screening tool than the PCL-C, in terms of establishing potential PTSD, as it contains a version with a brief assessment of 'criterion A', which relates to a traumatic event. However, at the moment, only preliminary validation of this assessment tool has taken place and suggested cut-off points "may be subject to change" (Weathers et al., 2013). For this reason, and also because the *DSM-5* (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013) was developed when the study was already being conducted, the PCL-C was retained as the screening tool for this study.

## **3.4 RESEARCH METHOD**

### **3.4.1 PARTICIPANTS- SAMPLING AND RECRUITMENT**

#### ***3.4.1.1 Inclusion criteria.***

The aim of IPA participant sampling is to find a homogeneous sample, which allows the researcher access to various subjective ways of understanding a particular experience, which in this current study was living with military partners who had been diagnosed with PTSD. The inclusion criteria were:

1. British male and female partners of military personnel with PTSD.
2. A score of more than 30 on the PCL-C.
3. Aged 18 years and over.

#### Rationale for inclusion criteria:

1. The reason for including only British participants was to contribute to almost non-existing research on the experiences of British partners of military personnel with PTSD.
2. The reason for using the PCL-C as a screening tool was to access participants who are most likely to be experiencing PTSD-like symptoms, which could suggest the possibility of ST.
3. The reason for inviting participants who were over 18 years old, was to avoid the possible need to obtain parental consent for participation, which could potentially have compromised confidentiality.

#### Participants

Eight female participants took part in the first part of the study (the PCL-C) and six of them achieved a score > 30 on the PCL-C questionnaire, so these six were interviewed. Short descriptions of participants with anonymised personal details are presented in Confidential Attachment 2.

The participants varied in regards to the length of their relationships, the fact that some of them had commenced a relationship with their military partners after they developed PTSD. There were also demographic differences such as age, marital and parental status and in regards to employment. Despite the participant sample being diverse, this did not appear to impact negatively on the trustworthiness of the study findings. This was possible because all participants were negatively affected by living with their military partners with PTSD. This was confirmed by the participants' PCL-C score, which was above the cut-off score and which suggested that they were all more likely to experience ST. Also, participants focused in the research interviews on similar issues, both in regards to how they were affected by them and how they coped with them. This allowed for establishing the shared common themes which were presented in the analysis of findings.

#### ***3.4.1.2 Sampling strategy.***

A purposive sampling strategy was adopted for this study, in order to gain access to the experiences of a certain group of people who are living with partners diagnosed with PTSD, within a limited timeframe. The participants were recruited via a number of UK charities and support organisations helping military personnel and their families. The organisations, who acted as gatekeepers, were identified through an Internet search, word of mouth, contacts made at the conferences and recommendation by organisations which the researcher had already contacted. An email was sent to all identified organisations (Appendix 2), explaining the study (Appendix 3) and details of their potential involvement, which

entailed advertising the research, for example, on their premises or website. They were asked to use a poster and/or leaflets provided (Appendix 4) and/or invitation to the study (Appendix 5) or any other forms of advertising that were appropriate and preferable to them.

Organisations which were interested in acting as gatekeepers sent their consent via e-mail. Afterwards, most of gatekeepers sent e-mails to members of their organisations or posted invitations to the study on their websites or Facebook pages. A further recruitment strategy considered was the use of social media, in the event that other avenues to recruitment were unsuccessful, but this did not become necessary.

The participants who contacted the researchers were also encouraged to let other people know about the research, a method of recruitment known as snowballing. Additionally, the researcher was open to other opportunities of finding potential participants through personal and professional contacts.

Potential participants were asked to contact the researcher by telephone or by sending an e-mail. They were provided with a Participant Information Sheet (Appendix 6), a Demographic Questionnaire (Appendix 7) and a Consent Form for their participation in the study (Appendix 8). The signed consent forms were obtained from participants prior to them taking part in the study.

### **3.5 DATA COLLECTION PROCEDURES**

Potential participants were asked to contact the researcher by telephone or e-mail. They were given the Participant Information Sheet (Appendix 6). They then had the opportunity to ask questions and were informed that the study might take place over the telephone, Skype or, if preferred, by face-to-face method.

Four participants chose the face-to-face method of completing the PCL-C questionnaire and taking part in the interview, and they were given the choice of having all documents (Participant Information Sheet (Appendix 6), Consent Form (Appendix 8) and Demographic Questionnaire (Appendix 7) sent to them via post/e-mail or receiving them at the meeting. Meetings were arranged in facilities convenient to participants, such as libraries and, in one instance, at the participant's home. Four other participants decided to complete the PCL-C questionnaire by telephone but went on to have a face-to-face interview. Documents were sent to them, together with a covering letter (Appendix 9), asking them to send back the signed consent form and Demographic Questionnaire electronically (with their electronic signature) or in a pre-paid and pre-addressed envelope. After obtaining signed consent forms, the researcher arranged with participants dates and times for their participation in the interview.

Consenting participants individually completed the PCL-C and the researcher calculated the score. Participants who did not score 30 or above were thanked for taking part in the study and given an opportunity to talk about their experiences of taking part in the study. A Debrief Sheet (Appendix 10A) was provided to them with useful contacts in case they found themselves emotionally affected by the study. Participants who scored 30 or above were asked to take part in an interview (lasting approximately one hour) immediately after completing the PCL-C or, where the PCL-C were completed over the telephone, at a later date.

Semi-structured interviews were recorded digitally, during which an interview schedule (Appendix 11) was used consisting of nine open questions designed to help to facilitate and to explore in-depth participants' experiences. The questions were, however, adapted during the interviews and asked at appropriate and relevant times during participants'

narratives. The reason behind it was that it was important to ensure that, in line with IPA methodology, the research process was participant-led.

Moreover, the process of designing the interview schedule enabled the researcher to become more aware of her own pre-assumptions about participants' experiences which she needed to 'bracket off'. This resulted in producing more open interview questions.

The questions in the interview schedule related to topics such as: participants' relationship with their military partners, how their military partners' military experiences impact on home life and participants themselves and how participants coped with them. Each of the questions had various prompts attached to them. Before the interviews for participants who completed the PCL-C questionnaire over the phone – another Information Sheet was given (Appendix 12). After the interviews, participants were given an opportunity to talk about their experiences of taking part in the study, and provided with the debrief sheet (Appendix 10B). Afterwards, the researcher completed the Participants Log (Appendix 13), transcribed the recordings and started analysing the data.

### **3.6 DATA ANALYSIS**

The data was analysed using shared processes and principles used in IPA, which can be presented in subsequent stages. This does not suggest that the process is linear but rather that it maps out the researchers' movement between the part and the whole in 'the hermeneutic cycle' until it is finally written up as a coherent whole (Smith et al., 2009).

Stages of IPA analysis adopted for each interview (Smith et al., 2009):

1. Familiarizing oneself with the data and giving it full attention by:

- listening to the taped interview while reading the interviews transcripts;



- re-reading interview material;

- being aware and trying to 'bracket off' any assumptions, reflections and observations, in regards to the data, by writing them down in the research notebook but also comparing pre-assumptions which emerged when designing the interview schedule.

## 2. Making preliminary comments and notes using:

-descriptive comments, which focus on participant's particular phrases, words and ways of explanations;

-linguistic comments, which focus on how participants' language is used when talking about their experiences;

-conceptual comments, which allow the researcher to capture their initial interpretations of how participants make sense out of their experiences which will be influenced by the researcher's personal reflections;

## 3. Developing emergent themes:

The researcher gives particular attention to certain parts of the interviews while still being guided and impacted by the whole interview and drawing on his/her preliminary comments and notes.

## 4. Finding connections across emergent themes:

Looking for 'super-ordinate' themes by using several different analytic processes, which are mainly subsumption (emerging themes become 'super-ordinate' theme by constant comparison) but also abstraction (putting similar themes together), numeration (frequency of expressing participants' meanings), function (reasons for using certain phrases and

descriptions by participants which allow him or her to negotiate his/her position in the interview with the researcher).

An additional method of finding common themes involved working with the supervisory team on two transcripts. During this work supervisors compared and confirmed their analysis with the one conducted by the researcher.

5. Looking for shared patterns for all interviews.

### **3.7 ETHICAL CONSIDERATIONS**

The study was designed and conducted with acceptance of the University of Wolverhampton School of Applied Science Research Board and the University of Wolverhampton Behavioural Scientists Ethical Committee.

Participants were given written information about the content and focus of the study and were told that they could withdraw their participation at any stage. Participants were provided with the researcher's and supervisor's contact details in case they had any questions or concerns.

In order to minimise any risk of potential harm or unintended consequences for participants: all personal details collected in the study were used only for the purpose of contacting potential participants and those who had agreed to take part in the study. Participants' personal data was treated as confidential and was kept in a safe, locked place, to be destroyed when not needed any more for the purposes of this study. Interview data was also anonymised which means that participants' and their partners' names used in the project are not their real names.

The researcher was mindful of the necessity of being sensitive to the context of the study, which included normalizing participants' emotional reactions and knowing how to

contain them. To ensure participants' wellbeing after the interviews, they were provided with information about potential support they could access.

Moreover, as a professional, a trainee Counselling Psychologist bound by The British Psychological Society ethical standards of conduct (BPS, 2009), I needed to take into account the aspect of risk assessment for safeguarding my participants and their children. For this reason, it was decided to include information about confidentiality, and when it could be breached, at the beginning of the interviews.

The lone worker policy was adhered to the study which included letting someone know when and where the interviews were taking place and phoning a trusted person when the researcher started and finished each interview.

### **3.8 REFLEXIVITY**

I entered the research process feeling a sense of unfairness for the partners of military personnel. This stemmed from the lack of attention being given to them in the media during the conflicts in Iraq and Afghanistan, but also the lack of support available to them. The latter was discovered during the recruitment process and attending a UK conference on military personnel and their families' well-being. After contacting 47 UK organisations and charities helping military personnel and their families and informal support organisations, only some of them appeared to be supporting the families, and only six of them were willing to advertise the research.

I was aware of my frustration over these issues from the very beginning of my research and I made conscious efforts to 'bracket off' my thoughts and feelings, especially when interviewing participants. I did that by journaling about my thoughts and feelings before meeting participants and after transcription of their interviews.

Moreover, the lack of formal and informal support to partners in the UK influenced my decision to focus on the UK population. This decision was made despite my awareness that it may have been far easier to recruit participants from the USA, where the concept of partners' ST is widely recognised by professionals and partners themselves.

### **3.9 VALIDITY AND QUALITY**

IPA is a scientific method, which requires the use of guidelines for assessing its validity and quality, which refers to “authenticity and consistency of interpretations grounded in data” (Yeh & Inman, 2007, p.386). There are various guidelines that show how validity and quality can be assessed but, for the purpose of this particular research project, Yardley's criteria (Yardley, 2008) will be used. They include: sensitivity to context of the study; commitment and rigour; transparency and coherence; impact and importance principles.

1. Sensitivity to context of the study is represented by the researcher in indirect and direct ways and is presented throughout each stage of this study. It requires establishing good rapport with gatekeepers during participant recruitment, choosing the right place for interviews, which would be easily accessible, comfortable and ensure confidentiality, and being sensitive to participants' emotional reactions and responses during interviews. The analysis stage requires being sensitive to the data by being able to evidence researcher's interpretations in participants' narratives and by making careful and logical general comments. Finally, claims made in the write-up stage need to directly stem from the provided data. Also, the researcher needs to be sensitive about the appropriateness of including particular comments and thoughts of participants.

2. Commitment and rigour/thoroughness which means that the researcher needs to offer the care and attention to all stages of the study, quality of the interviews and reasons for highlighting particular extracts of participant data in the write-up.

This stage of checking ‘validity and quality’ of the study could be enhanced by giving participants a copy of research findings to validate if researcher’s interpretation of them is an accurate representation of their experiences. This could be done by, for example, giving participants either the transcripts or analysis to check for its accuracy. In the case of this study, it was decided against introducing this process as asking participants to revisit their written descriptions of traumatic and difficult experiences, without any emotional support available to them during this process, seemed to be unethical.

3. Transparency and coherence refers to the clarity of design and rationality and logic of researcher’s arguments, themes present in the analysis and compatibility with IPA principles.

4. Impact and importance refers to the contribution of the study, in the sense of it claiming something interesting and thought-provoking, significant or valuable.

## CHAPTER 4 - ANALYSIS OF FINDINGS

In this chapter, the findings from six in-depth semi-structured interviews with female participants will be presented (see also Confidential Attachment 1). The findings will be structured around six major themes, which are a representation of the most prominent participants' issues and their impact on participants' lives. Each major theme encompasses several minor themes:

MAJOR THEME	SUBTHEME
Unpredictability of military partners' behaviours and moods	Mood swings;  Anger;  Violence;  Impact on the family;  Ongoing anxiety
Hypervigilance	Being careful what they say;  Being careful what they do;  Disclosure;  Consequences of their actions
Triggers to military partners' behaviours and moods	Individual triggers;  Common triggers;  Hopelessness of their actions;

A sense of loss	<p>Military partners' losses;</p> <p>Military partners' emotional numbness;</p> <p>Loss of a partner;</p> <p>Damages to the relationship;</p> <p>Loss of a relationship;</p> <p>Loss of fathers to their children;</p> <p>Loss of oneself;</p>
Adaptations	<p>Work choices and arrangements;</p> <p>Domestic arrangements;</p> <p>Social contacts;</p> <p>Self-care;</p> <p>Role transformation;</p> <p>Should I stay or go?;</p>
Loneliness	<p>Loneliness at home;</p> <p>Social loneliness;</p> <p>Loneliness within a wider society;</p>

Table 1: Major and minor themes

The themes will be discussed in relation to the three research questions: What are partners' experiences of living with military partners with PTSD?; How do partners cope

with the impact of living with military partners with PTSD?; Do partners living with military partners with PTSD experience ST and, if so, how is it represented?

#### **4.1 CHARACTERISTICS OF THE SAMPLE**

Overlapping themes for all participant life stories emerged despite differing characteristics of participants and their military partners (see Confidential Attachment 2). This suggests that PTSD has a significant impact on partners, regardless of their differing personal and relationship circumstances. The differences between participants' situations included the length of the relationships and the fact that some of them commenced a relationship with their military partners after they developed PTSD. There were also demographic differences such as age, marital and parental status. Also, one participant confessed to a history of her own traumatic experiences. Differences within the military partners' sample included status of their service- being in active service or being a veteran with variable lengths of military service and time since they left the army. Although all of military partners were diagnosed with PTSD, the time of the diagnosis since the exposure to their traumatic incidents varied between 1 and 10 years. There were also major differences in terms of professional support military partners received.

#### **4.2 MAJOR THEMES**

##### **4.2.1 UNPREDICTABILITY OF MILITARY PARTNERS' BEHAVIOURS AND MOODS**

This theme reflects the short and long-term impact of military partners' behaviours and moods on participants. This was the first and the most talked about issue in all interviews, suggesting its overwhelming impact on participants' everyday lives. As a result,



the theme is presented first and is a foundation for the various other issues discussed by participants. This theme relates to all three research questions.

#### **4.2.1.1 Findings.**

Participants' lives are characterised by the issue of unpredictability of their military partners' behaviours and moods, which results in them being constantly prepared for the unexpected. This seems to be especially difficult in relation to military partners' short-temper and mood swings. Participants talked about not knowing what to expect when they come home as their military partners might be either in a good mood or upset, irritable, angry, upbeat or depressed and lethargic. One of participants, Carol, explained:

*“Yeah, like the main one is (-) This is quite a big (-) the mood swings by that I mean: is he going to be really intense? Is he going to be really upset? Is he going to be over the top, excitable, happy that day? So you just don't know what you are going to get some days so those are like that I'd say is the hardest to live with.”*

Participants cannot know or predict what moods their military partners will be, but they tend to hold an assumption that sooner or later they will start displaying some sort of negative mood and behaviour. This fact tends to occupy participants' minds constantly, not allowing them to enjoy their time together even on good days without conflicts. Carol described this notion as *“an elephant in the room”* (p.170) and Rachel explained this further:

*“I'd say probably if we get two, three weeks kind of spell where I'd say everything ticks along nicely. And then actually after it gets about two weeks I start to think right, O.K., when it's going to end? How is it going to end? Cause I know that it's going to end. I know that peace will be shattered somehow. So I suppose I start dreading that coming“.*

Participants are in constant fear of the possibility of escalation of military partners' moods, which would lead to arguments, or even anger outbursts, which are like "*a big, big explosion*" (Anna, p.42). Anna's and Carol's partners would storm out of the house to 'cool off' or, as in Tracey's case, the partner would be asked to leave the room or the house to vent his anger. In this way, Tracey makes her partner safely release piled up negative energy and emotions and, by doing that, she protects everyone else in the house from any escalation of his behaviour. She said:

*"He has a really bad temper now. I just try to avoid him. I tell him to leave the room or just to go outside for a fag or go for a run because he is in (unit) in the army so he loves his running and his fitness. So I just tell him to try to vent it in any way he possibly can, really."*

Although the unpredictability of military partners' behaviours was a consistent theme emerging from all narratives, there was variability in the interpretations of these behaviours. In some relationships partners' behaviours were less frequent and, because of that, participants did not see it as problematic. For example, although Katy mentioned occasions when her partner storms out of the room or becomes racially abusive, she did not call him aggressive. Also, although Carol talked about her partner becoming angry at times, she seemed more concerned about his mood swings and becoming emotional, rather than his anger. It seemed that although she would know how to deal with aggressive behaviour, she did not know how to react to his partner's re-occurring emotional displays. Other participants, however, clearly stated the presence of their military partners' anger in their relationships and some even associated it with the possibility of them becoming potentially violent. They, however, constantly negotiate this lingering fear, as presented by Anna:

*“He isn’t physically violent. He is verbally very, very aggressive but he’s not physically violent but there is, there is a fear, I think, because you can see that he could be, you know. I don’t think that he would ever (-) I don’t think he would hit necessary, but I think if he was going- it would be worse than that. If he’d snapped I think he would be seriously dangerous, you know.”*

In fact, it was only Rachel who had actually experienced her partner’s violent behaviour, which she explicitly described:

*“We had an argument. It ended up resulting in him chasing us around the house with a kitchen knife erm which, I’m not scared of him, because I’m, you know, I can look after myself plus if he’s that drunk you can push him and he would fall over anyway so I’m not scared of him to that degree, but I think when he didn’t get the reaction he wanted from this he basically stabbed the knife in his arm.”*

Although Rachel’s partner did not stab her, the incident resulted in her sustaining bruises on her arms. However, despite being physically hurt, she dismissed in the interview any risk to her life and revealed that her only concern was her partner’s physical and emotional state. In fact, she did not even say that she was scared or upset with what he did to her nor did she become emotional when talking about it. Although she did not state it herself, it was quite clear that bringing her attention only to her partner, both in the interview and while the incident was taking place, was her way of coping with what happened that night. Being rational, logical and completely focused on her military partner allows her to deal with even extremely difficult situations. Moreover, Rachel believes that she is emotionally and physically strong enough to ‘deal with’ her military partner should he become aggressive. This reassurance is her coping mechanism, similarly to Carol’s and Anna’s belief that if their partners ever became physically aggressive, they would leave them. Anna said:

*“He isn’t violent with us, there is no ... (-) I think that would be the limit, you know. I don’t think that even I would be that silly to put up with that.”*

Moreover, all participants apart from Rachel also reassured themselves that despite their concerns about their physical safety, their military partners have, in fact, never hurt them, nor their children. Carol said:

*“He’s never ever ever gone violent with me. That’s one thing I’m going to give to him. He’s looked very angry but I’m pretty tough so I said to him: “Don’t you talk to me like that” So I wouldn’t have him talking to me in a certain way but sometimes you can see in his face he is very angry he’s never gone beyond that.”*

Mary repeated that her partner has never hurt her or children a few times in the interview but after one of these reassurances, she became visibly upset and in a shaky voice confessed to being scared of leaving children with him.

Military partners’ negative moods and behaviours have also negative impact on their children as they can result in shouting at children in Mary’s family or calling children by derogatory names in Anna’s family. This creates tension in the whole family and could potentially escalate into an argument. Anna said:

*“He calls everyone names, you know. Everyone’s got names. Really derogatory names, you know. Anything that he can pick up on a bit of weakness he’ll call you that name because he, I don’t know, I don’t know, if he needs to feel like because I think he feels powerless he tries to be in charge he tries to take power so he’ll pick up on things and he’ll call you with names. Luckily my son laughs at, not laughs at him, but takes it as a joke and walks away, you know, but sometimes I can feel the tension, that he doesn’t want to do that always.”*

Anna stated that she was proud that her son was able to manage the conflicts with his father but there was much sadness in her voice when she was talking about it as she knows that her son took over responsibility for managing the conflicts between him and his father. She also knows that this takes an emotional toll on him. Moreover, when talking about their daughter's behaviour she expressed concern about the impact of her partner's behaviour on her personality as she became mistrusting, hypervigilant, suspicious and withdrawn. She said:

*“She’s very wary of new places and strangers, she is hypervigilant, she is very scared of terrorism and, of course, it’s very difficult to say whether she would have been like that. Anyway, who knows, but I think that it’s probably the way her dad is, the way that he is so overcautious and thinks that everyone is out to get him.”*

Anna is aware not only of the immediate effects of her partner's outbursts on their children, but also the cumulative effects on them of living with their father. As a result, Anna talked about taking their children out of the house so they would be away from the stress and tension in the house. When Anna talked about her efforts in doing so, there was a feeling that she wanted to compensate her children for what they have been through at home. This was also experienced when Mary talked about making the most of the weekends with her children, when her partner was away, to accumulate positive energy and the strength needed to face home life after he comes back home. Tracey also talked about the impact of arguments with her partner on their children. She explained:

*“If I do say something he takes it the wrong way and then we start having argument and I’ll get upset and angry and then I take it out on the kids. I don’t hit them but you just get stressed with kids and it’s just an instant thing. You don’t mean to but it’s just taking it out on people who are close to you really.”*

Although Tracey's partner might not shout at the children himself, Tracy shouts at them instead as she is affected by arguments with him. She unconsciously displaces her anger towards her partner onto their children and, as a result, they become indirect victims of the arguments between the partners.

#### ***4.2.2.2 Discussion.***

Participants face the ongoing unpredictability of their military partners' changing moods and behaviours which can result in, for example, arguments or even emotional abuse, such as being called by derogatory names. Moreover, despite only one participant being physically abused by her partner, most participants are mindful of the possibility of escalation of their military partners' behaviours, which could lead to them becoming physically aggressive. This suggests that witnessing over years different scales of their partners' negative behaviours made participants realise that they would be capable of becoming violent. Their worry has significant foundation in research which finds high correlation between violence and PTSD (Taft et al., 2011; MacManus et al., 2012; Angkaw et al., 2013) and adds to participants' already high emotional burden.

Unpredictability of partners' behaviours and moods cannot be ever fully resolved. This is reinforced by the fact that it has existed in relationships as long as 10 years, which demonstrates the long lasting effects of PTSD already noticed in various other studies (for example: Schnurr et al. 2003). This does not stop participants from trying to deal with that unpredictability, with the main focus placed on dealing with the possibility of partners displaying violent behaviours. Participants have different ways of negotiating the possible threat of their partners becoming physically violent. The choice depends on participants' vulnerabilities and strengths, which are a source of their confidence and self-esteem but also resilience, which is an ability to adapt and/or recover from traumatic and stressful

experiences (Southwick, Bonanno, Masten, Panter-Brick, Yehuda, 2014). As a result, the least confident participant presented only one coping mechanism - self-reassurance that her partner has never hurt them as she felt too vulnerable to challenge her partner or to speak up for herself. Participants with the strongest personalities and high self-confidence perceived themselves strong enough physically and/or emotionally to deal with their partners even if they became violent. Some of them also said that they would leave their partners if that happened. This is another coping mechanism, which they used to re-assure themselves of their existing sense of control.

Continuous exposure to military partners' outbursts of irritation, anger and potential aggressive behaviour (cluster E of PTSD symptoms (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013) is, apart from military partners' avoidance, the most difficult to deal with for partners, which also supports the findings of other studies (Evans et al., 2003). Moreover, it leads to an accumulation of its negative impact and turn into long-term, chronic consequences of living with military partners with unresolved PTSD which overshadows participants' everyday existence.

Ongoing and cumulative negative effects of being exposed to unpredictability of military partners' negative moods and behaviours is a prominent source of participants' ongoing ST because they are traumatised as a result of their military partners' traumatic experiences which led to their PTSD development. Although ongoing exposure to a traumatized person's suffering as the reason for ST development was already identified in other studies (for example: Lev-Wiesel & Amir, 2001) it still presents a challenge to the most popular ST definitions. According to these, essential components to the development of ST are: learning about traumatic experiences of a person suffering from PTSD and having deep empathy for this person and desire to help and support him/her (Figley, 1995).

Unpredictability dictates participants' lives but also the lives of their children. This points to the further interdependence of family members and the reciprocal impact of one's trauma, suggesting that PTSD is a family condition. ST involves both partners and their children who are directly and indirectly affected by their parents' behaviours and moods, which was already suggested in a phenomenon of a trans-generational transmission of trauma from parents diagnosed with PTSD to their children (Dinshtein et al., 2011; Yehuda et al., 1998). One explanation for the impact of PTSD on partners' children could be offered by family systems theory, which suggests that partners deal with their anxieties by focusing on the third person, most likely their child, in a process called 'triangulation' (MacKay, 2012). Although this might help partners to manage better their anxieties, it has a negative influence on the child in regards to his/her emotional, somatic and social symptoms. Moreover, children can be affected by parents' particular negative behaviours in a process of a family emotional projection (Miller, Anderson & Kaulana Keala, 2004). Parents who are, for example, anxious would perceive their children as having the same emotional attributes, which is then acted out by that child, making parents' perceptions real.

Participants are aware of the negative risk on their children risk but, although they try to compensate and protect their children from it, their actions are limited by their unpredictable home environments. Dealing with an indirect impact of their military partners' behaviours on their children seems to be particularly difficult because it results from a cumulative, undetectable on daily basis, effect. Furthermore, the behaviour of participants themselves, in response to their military partners' moods and behaviours (and arguably due to ST), might negatively affect their children. In order to avoid this, they need to have sufficient self-awareness of projecting their frustration or irritation with their military partners onto their children, so that they can challenge this.

#### **4.2.2 HYPERVIGILANCE**



This theme refers to participants' being in an ongoing state of anxiety, which is a consequence of the unpredictability of military partner's behaviours and moods. The theme helps to explore participants' experiences of living with their partners with PTSD and how they cope with their impact, thus addressing the first two research questions. The 'hypervigilance' theme is a natural response to the research question about participants' ST as it describes one observable PTSD characteristic.

#### ***4.2.2.1 Findings.***

Participants used phrases such as "walking on eggshells", "treading carefully", "being on the edge" to describe their home experiences. Each participant, apart from Carol, used at least one of those expressions. However, even Carol talked about needing to constantly watch out for her partner's changing and potentially negative mood:

*"Sometimes things will catch me when I'm unaware like when I'm tired so I've come in or I've had a long day and I come in and he is really tired and if Paul's mood isn't great then and I'm not dealing with that well this can very quickly escalate into a row or it can really upset him."*

In fact, Carol makes herself responsible for having an ongoing insight into her partner's moods, which seems an impossible task, in order to give her a sense of control over home life. Mary and Tracey's way of dealing with their home situation is being "*always on edge*" (Tracey, p.62). This is because Tracey is cautious of her partner as she never knows when his behaviour will escalate and worries that she will "*get it in the neck*" (p.62). Similarly, Mary and her family feel that they need to be prepared for any negative situation at home, wondering "*what sort of mood he is going to be in*" (p.16).

Although this has a draining effect on Mary's children, she tries to manage it by explaining to them that their father's behaviour results from mental health illness and is not personal, not aimed at them. She also might have hoped that this explanation would make her children's reaction to their father's behaviours less abrupt or aggressive in the future. This is important for Mary, who has been noticing that her children started having "*their own voices*" (p.20), which means that they answer their father back, which in turn aggravates his negative behaviour and scares Mary. However, the problem is that even Mary doubts if her partner's behaviour can be truly explained only by his PTSD and questions herself: "*I don't know, if I'm trying to convince them or myself.*" (p.29)

Anna expressed, in a slightly different way, being in this state of constant anxiety, using the "*walking on eggshells*" (p.40) expression. This referred both to not triggering her partner's behaviour but also trying to minimise chances of its escalation during a conflict:

*"It's a bit like walking on the eggshells, you know. You're very careful not to crack things. You tread very carefully in the house because none of us want an argument or a flare-up or anything like that so we tend to try and let get him get away with as much as possible"*

Also Rachel articulated how important it is for her to be always prepared to deal with and manage with her partner's behaviour. As a result, she stopped, for instance, drinking alcohol so she could be more prepared to deal with any difficulties which might arise. Most importantly, Rachel feels responsible for her partner's life, which seems to be overwhelming her existence. This self-promise stems from her deep love, care and desire to help him, but there seems to be also an element of personal determination in making a positive change to someone else's life. She said:

*“I suppose a lot of the time I feel it’s my job to keep him alive and that’s quite honest.”*

Although it was only Rachel’s partner who was at actual risk of hurting himself, other participants are reminded about this possibility when watching military TV programmes, finding about other soldiers killing themselves and knowing their partners’ history of suicidal attempts or self-harm from before they met. This knowledge puts enormous responsibility on participants,

Participants are careful about what and how they say things to their partners, who tend to take everything very literally or the wrong way. Mary’s partner, for example, has accused her of not being able to understand him, because she has never been in the military. This might be one of the reasons why military partners do not generally talk about their military or traumatic experiences, unless persistently prompted, as they were by some participants such as Rachel or Carol. At the same time, Katy’s partner was an exception in that he had finally started talking openly about his traumatic experiences. However, he does this at any time during the day, forcing Katy to stop doing her activities and listen to him without any interruptions and no follow-up discussion afterwards. His monologue leaves Katy feeling isolated and hurt, as he does not take into account how she might be affected by his narrative. She also does not know how to react to these monologues as they normally do not even have trivial day-to-day conversations, which suggests that if disclosure takes place in relationships with no close connection, recipients of the disclosure might be emotionally unprepared for it. As a result, Katy’s reaction is silence as she knows that she is not allowed to interrupt him because if she did - it would irritate him. She said:

*“I could be in the middle of the programme and he will come down and sit and talk and I’ve got to stop and then “O.K.” (uncomfortable laughter) but I’m not allowed to*

*interrupt him but if I say "can I talk to you?" He will say: "No. I don't want to talk. I'm not in a mood".*

Katy and Anna both stopped asking their military partners any questions which would require them making any decisions, as this could lead to an argument. Mary and Carol became careful what and who they spoke to as their partners feel uncomfortable if they talk about them. Carol's partner is worried about military confidentiality, while Mary's partner is jealous of her having any contacts with men. Mary described one of the incidents in which talking to her mutual male friend at their home arose her partner's suspicion:

*"He has like he has friends I know since I met him sort of thing. A few months ago he even (-) this friend comes to the house all the time and he thought I was, because I was talking to him too much, he thought, you know, I was going to run off with him."*

Participants are on guard also in regards to their actions and the way they balance and judge the appropriateness of their behaviours and self-designed interventions. As a result, Anna, for example, confessed to treating her partner in "a management kind of way"(p.50). She even asked professionals involved in his care about his "psychiatric profile" (p.50) and if the family is safe with him, which suggests her level of concern, if not fear, about her partner's possible behaviour. Participants would also leave their partners to themselves, especially when they are in a negative, agitated mood, and this is one of the most common interventions they use. Mary explained:

*"It makes us nervous all the time because we don't know when he is going to kick off but... I think we just sort of leave him to himself when he gets on one and just go out and do something."*

Mary uses this strategy in order not to aggravate her partner's negative mood and this is probably the easiest and the most efficient way to do so as her military partner is not keen on explaining what makes him feel angry, frustrated or irritated. Rachel also leaves her partner to himself when he is in an agitated mood but, instead of never talking about what happened, as Mary does, she would wait for the right time to discuss with him a particular incident. She does it in this way because she had learnt that challenging her partner about some of his behaviours straight after it has taken place is counterproductive. She explained this by drawing on one of the incidents:

*"I've had to learn to wait and think - OK, I can't address it now because I know it's not a good time. I'm gonna have to wait until it's a better time - so sometimes I have to wait two or three weeks when I kind of could say: Can you remember? Which is quite difficult cause he can't"*

Rachel learnt to choose wisely which battles she wants to win when challenging some issues with her partner. However her main priority is always for him to gain an insight into his behaviour as this, she seems to be hoping, could stop him from repeating certain behaviours in the future. This almost educational approach, which she adopts, results from an ongoing desire to help her partner. It also makes her feel, to some extent, in charge of the home situation, as she is the one who seems to understand more about her partner's behaviour than he does, but also she makes decisions on how and when to bring some issues up. Rachel's pro-active attitude to addressing certain issues is a reflection of her confidence and particular resilience. This can also be seen in Carol, who commented that *"Stuff happens in life. You deal with it and then you enjoy the peace"* (p.150), and in Tracey. However, in order to try to make a positive change, they also need to be constantly 'on guard' with anything that happens at home and react accordingly, bearing in mind both the short and long term consequences of their reactions. This is quite difficult, though, because they need to be

vigilant all the time because, as Anna explained, their military partners' PTSD has an ongoing effect both on their military partners and their families:

*“It's 24 hours a day non-stop for everyone around that person not just for the person who's got it but for everyone else too.”*

This makes Anna, but also a few other participants, feel tired and drained.

#### **4.2.2.2 Discussion.**

Partners are in a constant state of hypervigilance as a result of their military partners' behaviours and moods, which pose ongoing threats to their emotional well-being and potential physical safety. They are in abnormal, anxious arousal as they need to be on the 'watch out' for potential triggers of their military partners' unpredictable behaviours and react to them accordingly. Also, participants might become hypervigilant in a more emotional sense, as military partners' PTSD imposes changes not only to the marital eco-system but to various unconscious processes taking place between the partners. This can take the form of a 'couple dance' which regulates anxieties (Middelberg, 2001). As a result, the unpredictability of military partners' behaviours and moods might have evoked anxieties and fears dictated by participants' particular attachment patterns. It might have also disturbed patterns of unconscious projections during which partners project unwanted emotions and perceived negatively certain parts of 'self' on each other (Lemma, 2003). In this process, partners become emotional containers, which can be crucial when dealing with an impact of a traumatic experience. However, because military partners' behaviours and emotional responses have changed as a result of their PTSD, participants might, at an unconscious level, not want to be emotional containers for them. They might simply not want to be continuously exposed to their military partners' negative changes. As a result, they might defend themselves from that by becoming 'on guard' in their relationships and avoiding exposure to

certain behaviours and emotions of their military partners. This, however, has a negative reciprocal impact on their military partners, who might feel threatened and rejected, thus making their moods and behaviours even more unpredictable.

Becoming hypervigilant is also participants' coping mechanism. By applying careful ways of functioning in what they say and do, they can avoid escalation of their partners' negative behaviours, which means that they can protect themselves and their families but also their partners as some of them feel responsible for their lives. The worry of army participants committing suicide is justifiable, as in various studies PTSD in military personnel was associated with suicide risk (Lemaire & Graham, 2011; Rozanov & Carli, 2012). This was also confirmed in a literature review on military and veterans' posttraumatic mental health (Australian Centre for Posttraumatic Mental Health, 2014).

Participants introduce, with no guidance and support, self-designed covert and overt strategies which are less or more suitable or helpful than others. As a result, they might even use behaviour accommodation' strategies (Monson et al., 2009) which, although chosen with best intentions, might maintain partners' avoidant behaviour or increase their hyperarousal and aggressive behaviour. Interestingly, although covert strategies are chosen by all participants as they focus on protecting themselves and their families, overt strategies are adopted only by participants with the strongest personalities, for whom a sense of control is particularly important. Also, although this might be co-incidence rather than causal, participants in relationships with the shortest status are also those who come across as the most confident and resilient ones. A possible explanation of this can be that living in the hypervigilant state for a long time, damages their confidence in their self-designed strategies but also resilience which depends on personal characteristics but also on intensity of the stressful or traumatic situation and access to support (Robertson & Cooper, 2013) and which was found to be a positive predictor of couples' functioning (Melvin et al., 2012).

Participants' hypervigilant state is a PTSD symptom, referring to arousal and reactivity PTSD cluster (cluster E) (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013), which suggests that ST can manifest itself through observable PTSD-like symptoms (Figley, 1995). However, this is not straightforward with other PTSD symptoms, which relate closely to details of military partners' traumatic incidents, as very few participants have full knowledge of them. This is because military partners' traumatic experiences as military partners, in general, simply avoid talking about them. For example, participants would not be able to present PTSD symptoms such as: avoidance of stimuli associated with the traumatic incident (cluster C) or present intrusion symptoms (cluster B) (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013).

Although military partners might avoid talking about their traumatic experience, all participants seemed to have some idea of what had happened to them, which might be a result of collecting information about their experiences over the course of their whole relationships. They might also have had glimpses into the roots to their traumatic experiences during military partners' nightmares or flashbacks. Interestingly, participants spent very little time in the interviews on even talking about nightmares or flashbacks. This might be that because these appear sporadically and are temporary or because they do not relate to family and participants, so do not pose a threat to them.

Findings suggest that participants having partial knowledge of their military partners' traumatic experiences might be enough for them to develop ST, which was noted also in other studies (Caspi et al., 2010; Lev-Wiesel & Amir 2001). Moreover, when taking into account participants' responses from the PCL-C screening tool, all interviewed participants achieved the cut-off point 30, which meant they all presented PTSD-like symptoms. Although they all presented PTSD symptoms, however, it cannot be assumed that all of these symptoms would be revealed in their narratives. It may be that participants referred only to



those that they found most difficult. Another explanation might be that people with ST might display some but not all PTSD symptoms.

#### **4.2.3 TRIGGERS TO MILITARY PARTNERS' BEHAVIOURS AND MOODS**

This theme is a natural consequence of the two previous themes. It refers to participants' attempts to understand but also to predict and de-escalate military partners' negative moods and behaviours, by continuously engaging in the process of finding potential triggers for these. The theme relates to all three research questions. With regards to the ST phenomenon, it provides an opportunity to discuss the notion of empathy, which is another essential component of ST.

##### ***4.2.3.1 Findings.***

Participants confessed to constantly learning various triggers to their military partners' negative behaviour, which is the most commonly used coping mechanism. It helps participants to reduce the level of unpredictability of their military partners' behaviours and allows them to gain some control in dealing with day-to-day situations by knowing how to avoid or de-escalate conflicts. Participants gave various examples of learning triggers to their military partners' behaviours. For example, the triggers for Carol's partner getting angry involve her not completing domestic tasks or not being compliant with timings set up by him, such as timings relating to bedtime or spending time together. Carol's partner appears to want their relationship to function in a more structured way, as if they were in a military camp, and this creates stress for her:

*“He wants our home to be like a military camp like: “So how long you are going to be on this?” “Well, I don't know, you know”. He hates not being in control of timings and that has got to be, that's got to be PTSD cause it's that constant pressure of*

*we must do this by this time oh we must do by that time. It's stressful. It's really stressful."*

Mary's partner's triggers are around not putting an item back in its previous place, or regarding discipline when children answer him back. Other significant triggers are his jealousy about Mary speaking to other men, as he thinks she will leave him for them. Moreover, Mary's partner does not like being asked questions about his military experiences and his immediate response is that: *"You haven't been in the military so we don't understand what he's gone through"* (p.19). Anna's partner would get angry as a result of being frustrated with finding some things difficult, such as receiving a letter which he does not understand. Rachel considers alcohol as a trigger to her partner's anger outbursts but she is also aware of a particular pattern to her partner's behaviour which deteriorates in winter. At the same time, she accepts the fact that every single bad patch of her partners' behaviour is caused by something else. This makes her and other participants constantly *"trying to work out where the behaviour comes from"* (Carol, p.148) by deducing a connection between their military partners' anger outbursts or changes in their moods with potential reasons for them. The difficulty is that they have very little information and use the aftermath of incidents as the starting points of their exploration. Also, this can be emotionally difficult because, although they want to find out triggers which could help to predict or manage future conflicts, they need to be careful in order not to aggravate their partners' negative behaviour.

Moreover, some participants, like Rachel and Anna, tried to make sense of their military partners' behaviours and moods by taking blame for them. Rachel explained:

*"And for a long, long time, especially early on in our relationship, cause I always thought it was about me and it was like "Oh, have I done something wrong to upset him? Have I said something? Have I done something? Is he unhappy with us about something?" And it's really hard cause you ask him questions and he's like "I'm fine.*

*No. Yes". And it's just like: "Just tell us what have I done?!" (shouting out). And for a long time it was just like a guessing game. After a while I kind of thought actually I don't think any of this is about me."*

It took Rachel a long time to understand that she was not to blame for her partner's reactions. However, self-blame seemed to be less difficult to cope with, at one point, than being surrounded by unexplained behaviours.

When reflecting on participants' narratives, it became clear that there are also some common potential triggers to military partners' frustration and irritation which can easily transform into anger. A significant trigger to those feelings is asking military partners about reasons to their negative moods and behaviours as this seems to escalate them. Anna described this:

*I really had to learn (saying it slowly and with attention) and, I didn't at first (speeding up, saying it in a higher voice). I've not always been the way I am now. At first, I didn't argue back but I questioned him more. My response to someone not answering my question was for me to ask more questions: "Well, why?", "What makes you upset?" "What's the matter?", you know. And that just makes it worse and worse and worse."*

Despite learning this trigger, Anna finds it difficult not asking her partner questions because she sees it as a natural part of sharing a life with someone. However, knowing the risks, she limits the questions and does not ask any when he becomes angry. Instead, she leaves him to himself.

Questions relating to decision-making can also aggravate military partners' negative moods. This adds work-load and responsibility to participants' lives as any planning and

organisational tasks tend to fall on them. For example, Katy's partner gets irritated and frustrated with questions relating to their child or household, such as what colours of walls he would prefer. As a result, Katy learnt that the best thing was to make decisions for the whole family. She said:

*"I've quickly learnt over ten years to (-) I don't think, I don't involve him. I tell him what's happening but there is no proper discussion like you would sit and have it."*

Anna's partner also gets angry even when she asks him questions as simple as what he wants for dinner and Tracey's partner does not even get involved with activities with their very small children. Carol's partner also feels overwhelmed with every-day problems, such as unpaid bills, which take the form of much bigger, overwhelming issues he finds difficult to cope with. In fact, he confessed to finding it difficult to readjust to a civilian life and to missing the simplicity of military life. Carol said:

*"He loves out there because it's so simple. You get up, you eat, you fight, you train, you go to bed. You're with men. You don't have to worry about (-) He says he finds life harder cause you have to worry about bills and you have to worry about money and you have to worry about like planning ahead."*

Although Carol finds her partner's behaviour frustrating she has, at least, a clear understanding as to why he is behaving in this way. Other military partners do not seem to open up so willingly about their emotional well-being and participants need to use sensitive approaches and prompt them in careful ways about it. This requires full dedication to the task and can be emotionally overwhelming. Only a few participants, like Rachel, are actively involved in this process. Even Rachel calls the process "*a guessing game*" (p.108) in which her partner is "*a jigsaw*" (p.83) that she continuously tries to put together. However, every

time she finds one more element of that jigsaw, she realises that there is another one that she is missing.

Mary, Anna, Carol, Katy and Tracey raised another common trigger for their partners' negative behaviour, which is a tendency to want to spend time in isolation in their houses. They would do this even if they have guests in the house, as mentioned by Anna, Tracey and Katy, as they think that others are “*ganging up*” (Tracey, p.69) on them. When military partners decide, without giving any explanation, to remove themselves from the company of their friends, this creates a socially awkward situation. As a result, participants need to explain their partners' behaviours to their friends, although without being too explicit about the real reasons for their partners' disappearance. This puts participants in a difficult position as they are torn between loyalty to their partners and empathy for their guests who have been abandoned by their host.

Knowing some of the triggers to military partners' behaviour is helpful as it reduces levels of unpredictability around military partners' behaviours and allows participants to predict and de-escalate potential conflicts. However, participants are continuously taken by surprise by their partners' frustration, irritation or anger outbursts inflicted by new triggers, which can be absolutely anything. Anna, Mary and Katy, all of whom have been in their relationships for over ten years, confirmed the latter when asked what can trigger their partners' aggressive behaviours. Katy also explained how much this can still shock her:

*“He will then storm off upstairs and I’m just like: what has just happened there? I don’t know what’s going on. It’s very difficult to live in I feel like I’m on the battlefield. It’s like war environment.”*

Even if participants continuously learn certain triggers, they know that new triggers or unexplained behaviours appear in their places. This means that participants' lives are

characterised by lack of stability or reassurance that things will change permanently for better. Tracey said:

*“I feel like it’s one of those things which is never going to end and that this is going to be like this for the rest of our lives.”*

In fact, Mary, Katy and Anna unanimously said that their partners’ conditions and behaviours have deteriorated over the years, in the sense that they are more challenging to cope with. This makes them feel helpless and hopeless, which is aggravated by seeing their military partners’ ongoing struggles.

#### **4.2.3.2 Discussion.**

Participants constantly engage in the process of finding out triggers for military partners’ behaviours, with military partners rarely talking about their feelings, let alone explaining their moods and behaviours. Military partners’ emotional numbness is likely to be a direct impact of PTSD, but can also result from wanting to protect themselves and their families from emotional pain, caused by hearing about their traumatic experiences (Ray & Vanstone, 2009). It might also stem from a belief that participants would not understand them because they were not in the army. This might be explained by the fact that military partners are still very much embedded in military culture, involving a sense of ‘mission’ and a set of core values such as honour, courage and commitment (DeVries, Hughes, Watson & Moore, 2012). This is especially the case for participants who entered their relationships after their partners left the army, resulting in them not considering themselves to be ‘army wives’.

Despite participants’ continuous efforts, new unexplained behaviours replace the old ones and military partners’ anger can be triggered by ‘absolutely anything’. Participants carry an overwhelming responsibility, with little prospect of actually changing their partners’

behaviours, but they continue to engage in this process because it gives them an opportunity to try to predict potential risk to themselves, their families and to their military partners themselves. This process might be frustrating and might suggest that they are trapped by their life circumstances. On the other hand, engaging in the process of finding triggers for military partners' behaviours also gives them a sense of control. After learning a new trigger, they can introduce appropriate coping strategies helping them to predict, manage or de-escalate their military partners' behaviours. This also limits the unpredictability of military partners' behaviours and moods and, although it might have temporary effects, gives them a sense of achievement. Moreover, participants in short-length relationships find this process more empowering than the others, as it gives them hope of bringing positive changes in the future. It also enables them to gather more understanding of their military partners, which is highly desired.

The desire to understand their partners' actions and experiences stimulates participants to express empathy towards their military partners, and it is at the centre of development of ST (Figley, 1995). In fact, in the literature focusing on gender comparison of ST on 12 studies, it was found that females are at greater risk of developing ST because they are generally more empathetic (Baum, 2014). Empathy expressed by participants might be their way of managing shattered beliefs in "personal invulnerability, a perception of the world being meaningful and orderly, and a positive view of oneself" (Gilbert, 1998, p.60) leading to their traumatic stress. Participants might want to take on their military partners' experiences and feelings to make sense out of them and to restore their beliefs but also to build new dyadic interactions and assumptions about their relationships and roles within it.

However, participants appear to express varying levels of empathy. Participants of shorter length relationships, in general, came across as more empathetic to their military partners. This might suggest that participants in relationships with longer status experience

‘empathetic burnout’. The latter might be a result of long exposure to their military partners’ negative moods and behaviours and ongoing efforts in finding triggers for them, while being in a permanent state of hypervigilance and anxiety. Participants might have realised that their empathic efforts do not bring expected improvement in, for example, helping their partners or improving the quality of their relationships. Moreover, their efforts have not been reciprocated or appreciated, and sometimes even met with aggression. Consequently, participants might want to distance themselves from their military partners to protect themselves from feeling rejected (Lev-Wiesel & Amir, 2001).

Lack of a sense of achievement and distancing themselves from their partners’ suffering after prolonged exposure to it might lead to compassion fatigue (Figley, 1995, 1998). However, what participants might have developed is, in fact, ST because they were also exposed to their traumatized partners’ emotional, biological, behaviours and cognitive PTSD symptoms. It is these symptoms that can be traumatizing and evoke a similar range of symptoms in participants, which in turn will have a reciprocal impact on their military partners (Figley, 1995). The cycle is repeated and with every turn it affects and is affected by ten elements of couple functioning, which can be explained by the CATS model (Nelson Goff & Smith, 2005). Moreover, because each partner’s responses to traumatic events or ST is affected by partners’ predisposing factors and resources, this could explain why certain participants come across as more traumatized than others.

#### **4.2.4 A SENSE OF LOSS**

This theme refers to a sense of loss in various areas of participants’ lives. The theme relates to the first research question, which asks about the impact of living with military partners with PTSD.

##### ***4.2.4.1 Findings.***



Participants claimed that their military partners have changed significantly after being exposed to a traumatic incident which resulted in them developing PTSD, and that they seemed to be 'different people'. This consequently carries an overwhelming sense of loss of partners and relationships and, as a result, loss of intimacy that used to exist. Tracey explicitly described this in various parts of her interview. She said:

*“After he went off to Afghanistan I noticed the changes in him straight away. It is as if it wasn't him. As if he was someone else. He looked like Brian but it didn't feel like Brian.”*

Tracey's partner might be physically the same but he came back changed emotionally, which made him come across like a different person. As a result, they do not have emotional closeness anymore and they cannot relate to each other as they used to. Tracey explained it further:

*“He is not the person I fell in love with. It feels like he is someone else. I would say this is the hardest thing. He is not the lovable, laughable person I fell in love with. I used to, we all used to be able to play and fight, have a joke, have a laugh but now we can't really do that anymore because of how he reacts to a lot of things. You can have a joke with him but he takes it completely the wrong way.”*

Carol described the loss of her partner and her relationship with him as a mourning process. She also mourns the loss of the future they both were planning to have and she knows that they need to learn to love each other once again. She said:

*“I think it's difficult because I saw him what he was like before, when I met him and I fell in love with him. Like the guy I felt in love with was really confident and really fun and now I look back and maybe it was a bit bravado. But, at the same*

*time, I almost mourn the loss of, like I love my husband and I love who he is now but it has been a real learning to love like it is in sickness and health you have to learn to love a new Paul and love who he's become."*

Carol's description encompasses her deep sadness, which was characteristic of all participants' stories, as well as highlighting the constant efforts required in re-building and replacing what was lost in the relationships.

All participants, apart from Rachel, were explicit about how much their current relationships had worsened over the years since their military partners were exposed to the traumatic events causing their PTSD. They described various changes they noticed in their partners, such as changes in their personalities (becoming less confident and relaxed, for example, or more stressed, tense, anxious and withdrawn). Some military partners had also become compulsive in their expectations regarding time-keeping and completing tasks and become jealous and suspicious as they were worried that participants will leave them. Moreover, most of them struggled with daily tasks, as they involved decision-making which they find challenging. Moreover, Katy and Anna talked about their partners being paranoid in thinking that "*everyone is out to get*" them (Anna, p.39). In fact, Katy's partner even asked her if she put poison into his tea. They also tended to take things too literally and have rigid ways of thinking, as Anna explained:

*"He just has strange ways of being. I can't explain it in any other way (laughing). He is just very wary of people, he's, he's very black and white in his thinking. You know, there is no grey area, it's everything is either right or wrong. He doesn't like to talk. He doesn't enjoy conversation because he would already have made his mind up about something before the conversation starts and nothing that you say or do can change his mind on something."*

Anna's description suggests that it is not possible to have a conversation with her military partner who finds it difficult, if impossible, to see another person's point of view. This means that communication, one of the most important elements in healthy relationships, is significantly affected in Anna's relationship, which is also a re-occurring problem for all of other participants' relationships. However, the extent of this issue is less stark in couples where participants, such as Rachel, Tracey and Carol, make a constant conscious effort in encouraging their partners to 'open up' to them and actively implement strategies to change, rather than only to minimise, the severity of their partners' moods and behaviours. This does not change the fact that even Tracey talked about the loss of 'connection' that they used to have, which makes her feel that she is not in a romantic relationship anymore:

*"We do still love each other. We do still tell each other we love each other (sighs) (...)  
It's just the connection when he's in the mood, it is as if we are not in a relationship-  
as bad as it sounds. When he's like that, it's almost, it's almost as if we are not in a  
relationship. And sometimes I feel like, I wish we weren't in a relationship because of  
how bad it gets and not wanting to deal with him."*

Every single participant felt that their military partners did not know what impact their moods and behaviours were having on them. Participants felt that their partners found it difficult to empathize with them or to acknowledge their needs, wants or the difficulties that they were going through. Katy explained:

*"When I said the numbness, the emotional numbness was the worst- there is no  
relationship there and that's hard cause I've got needs and his needs come first for  
worse or better so that's difficult. I miss that closeness that we used to have."*

Most participants complained that despite living with their military partners, they are present only physically and not emotionally in the house. Military partners' emotional absence means

that participants cannot share with them their issues, concerns and worries as they lost the closest people and best friends they used to confide in. Moreover, military partners' physical presence in the house is a constant reminder of that loss. Interestingly, even in the relationships where participants, such as Rachel, Carol and Tracey, felt that they could communicate with their partners more effectively, participants did not feel that they could talk about how they really felt. They protect their military partners from blaming themselves or feeling guilty for the struggles that they are going through.

Military partners' emotional withdrawal also results in them not engaging much in family life. This was vocalised by all participants who have children, such as Katy, Anna, Mary and Tracey. This seems to carry an additional sense of loss for participants, with Katy calling herself "*a single parent*" (p.134). Tracey described how she struggles with her partner not showing much interest in their children:

*"Sometimes he doesn't want to get involved with kids at all and, really, that's hard".*

Although participants are saddened with this situation, they accept its reality and invest even more in their family lives, as if they want to compensate their children for this. Moreover, when they describe family dynamics they divide their families into two separate groups: 'us' - children and participants and 'him' – their partners. This suggests that military partners' limited involvement in family functioning, but also the way in which participants might negotiate their home reality. Their positioning themselves in the same group as their children might give them a sense of stability and belonging, because being a mother is a part of their lives which is not so directly affected by their military partners' PTSD.

Another form of significant loss which all participants referred to was- loss of self. Participants were unanimous in saying that their lives revolved entirely around their partners, as if they did not have their own lives anymore. Katy said that she felt as if her life was

“consumed by” (p.131) her partner. Tracey confessed that she comes last in everything and that she does not look after herself the way she used to. She said that she has “*just gone out of the window*” (p.72) and that this is a result of needing to look after her partner, as well as her children. Rachel said that everything about her life has changed since they had got together as a couple:

*“We basically need to balance our whole life around him and whatever is happening with him at any given time. So I’d say 99.99% of my world is based around him and not me.”*

Rachel’s reality sounds overwhelming and impossible to deal with. However, she accepts that her existence at home and in a relationship is valued at as little as 0.01% because her military partner is, in fact, her whole life. She has dedicated herself to him, thus becoming a different, more empathetic and caring person than before. She said:

*“I don’t think he would ever understand how much impact he’s had actually literally on every single thing in my life. But I have to say a lot of it is good as well. I’ve actually changed a lot for the better because of Michael. Before Michael I was self-centered, selfish, only thought of me. I was in a long term relationship prior to Michael, where, basically, I just walked all over the bloke. He let us. He was a doormat. For the first time I’ve put somebody first. Literally, the first time in my life I think about somebody first and foremost. I’ve (-) I think Michael has actually showed me an emotional side, compassionate side that I’ve never ever had before so, you know, as much as (-) yeah, there are days that are tough but there are other sides where, actually, I think I’m a better person for it.”*

Rachel's experience of living with her partner, although challenging, has allowed her to grow as a person and to appreciate herself more. She is grateful to her partner for that and appreciates every single thing he does for her, such as making dinner or vacuuming the house. She does not expect anything more in return for supporting him. His love and the fact that she can make a positive change to his life is enough for her.

Rachel is the only participant who referred to experiencing a positive change as a result of her partner's condition. Other participants long for the kind of people they used to be. Rachel, Anna and Katy referred to having their personalities changed. Katy, for instance, used to have a strong personality but now she is afraid to voice her opinion at home or at work and she blames her partner for that. She has also become more withdrawn from her friends and family. Anna also talked openly about becoming a different person, which sounded as if she had lost a significant part of self. She said:

*"It's as if I have to find myself some mornings, you know, and remind myself that I can smile and be happy and enjoy the simple things in life because if I had a bad day before it is a difficult thing to do, you know. I was always a really happy, positive kind of person and I don't think things really got me down, you know, but some days I have to, I struggle to feel like that again."*

Moreover, Anna feels, embarrassed about becoming a different person, someone who allows herself to be treated negatively by her partner and blames herself for not doing anything about it.

#### **4.2.4.2 Discussion.**

Participants experience a loss of their partners as a result of changes in their behaviours, moods, personalities and ways of interpreting the world, which is a direct result of them suffering from PTSD. This, consequently, has had an impact on intimacy and other

aspects of their romantic relationships. This has resulted in disruption of the ‘couple fit’, which is the unconscious bond between partners created at the beginning of their relationships which made them choose each other and unconsciously bond together (Nyberg, 2007). The creation of this fit was made as a result of partners becoming the recipients of each other’s unconscious projections for “the purposes of development *and* defence” (Ruszczyński, 1993, p.204). However, military partners’ traumatic experience, which led to PTSD development, ruptures the bond between the partners, which was a source of psychological resonance, comfort and security (Scharff & Scharff, 2008). It is as if changes in military partners’ cognitive, biological, emotional and behavioural characteristics inflicted by PTSD made them different people whom participants need to learn from the start. In a reaction to this, participants also changed and so did their romantic relationship. Moreover, the core values to their relationship, based on their cultural understanding or gender or family roles, have been damaged, although expectations of them might have remained the same for both partners in military relationships (Tews-Kozłowski & King, 2012).

Changes to participants’ romantic relationships also include a potential transformation in the type of love they might share now. This could be described using Sternberg’s ‘triangular theory of love’ model (Sternberg, 1997). The model suggests that love composes of three elements: intimacy, passion and commitment which, in various combinations, provides eight different types of love. It seems that for many participants the type of ideal love they might have had - ‘consummate love’ (a combination of intimacy, passion and commitment) has changed into other types of love. It might have changes into types of love which do not include intimacy, for example, as this is quite difficult to achieve in a relationship where one partner becomes emotionally absent. The new type of love could be described as ‘empty love’, which is composed of commitment or ‘fatuous love’, based on passion and commitment.

Participants grieve for their losses and their reaction to these can be explained using Kübler-Ross's non-linear model of grieving, composed of denial, anger, bargaining, depression and acceptance stages (Kübler-Ross & Kessler, 2014). It seems that all participants are at different stages of that process and still negotiate their place within these stages, as became apparent during the interviews. For instance, participants expressed their anger and frustration at being solely responsible for their military partners' well-being but then, shortly after, they talked about how sad they are seeing their partners going through their various struggles. Moreover, it seems that only one participant seemed to be able to reach at times the last stage of the grieving process - acceptance- but even for her the process of grieving was ongoing. Achieving acceptance is difficult because participants experience 'ambiguous loss' (Dekel & Monson, 2010), as their military partners are physically present but emotionally absent. Their loss is not connected with a definitive, physical ending, such as when grieving for someone who has died.

Participants also have a sense of the loss of their previous lives, a finding which also emerged in other studies (Dekel et al., 2005; Kimhi & Doron, 2013). Their lives revolve around their military partners, which leads to alterations in participants' identities and personalities, resulting in negative changes in their cognitions and moods. The latter is a representation of another PTSD cluster (cluster D) (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013), which is another observable demonstration of ST.

At the same time, one participant openly said that the experience of sharing a life and supporting her partner with PTSD made her a better person - more caring, empathetic and selfless. Despite being exposed to ongoing challenges she has benefited from her changing role, which can be explained by the concept of 'benefit finding', sometimes referred to as posttraumatic growth (Bower, Low, Moskowitz, Sepah & Epel, 2008) and is also recognised among caregivers (Kim, Carver, Schulz, Lucette & Cannady, 2013; Lum, Lo, Hooker &



Bekelman, 2014). ‘Benefit finding’ refers to achieving a set of positive changes stemming from being exposed to highly stressful events or traumatic life experiences (O’Dougherty Wright, Crawford & Sebastian 2007). This can mean accomplishing personal growth, such as creating new life philosophies and aims or various positive changes resulting in, for example, more family time or satisfactory relationships (Bower et al., 2008). ‘Benefit finding’ occurs under certain conditions, which correlate with each other, including the presence of increased levels of self-efficacy, resilience and optimism within a person and available social support (Cassidy, 2013). The participant who claimed to have benefitted from her changing role appears to present high levels of self-efficiency, optimism and resilience, which supports the concept. Despite not having much support, these features seem to be enough for her to focus mainly on positive aspects of her current life. It might be that these aspects are enough for her because she also sees some of her partner’s personal qualities as empowering.

Participants divide their relationships into ‘before’ and ‘after’ their partners started experiencing PTSD symptoms, and they also refer to processes of deterioration in their partners’ condition. This confirms that PTSD symptoms have a tendency to worsen with time (Thomas et al., 2010; Fear et al., 2010). A clear difference in the quality of relationships is especially prominent when military partners experienced traumatic experiences while already being in the relationship, as this gives participants a clear comparison of how their partners were before and after the traumatic incident. The difficulty is that not many participants have a clear understanding of the fact that a significant numbers of changes in their partners’ personalities, moods or behaviours are a result of PTSD. Because of that, they attribute changes in their partners to internal reasons rather than to external ones, such as PTSD. This creates for them more psychological distress, which can be explained by ‘the attributional model’ (Renshaw et al., 2014). According to the model, internal attributions have a more significant impact on participants than external ones as they refer to relational aspects of the

relationship. As a result, participants' might interpret their military partners' emotional withdrawal as rejection.

#### **4.2.5 ADAPTATIONS**

This theme relates to changes participants make in order to understanding and deal with their military partners' behaviours and moods. The theme relates to the first two research questions, exploring participants' experiences of living with their military partners with PTSD and how they cope with these experiences, while also touching on the research question regarding ST.

##### ***4.2.5.1 Findings.***

Participants referred to making various practical changes in their lives since their military partners developed PTSD or their symptoms worsened. These include work choices and work arrangements. Rachel, for example, decided to change jobs because her previous job role was too difficult to manage in her current home situation. She said:

*“It was too stressful trying to cope with a really busy and stressful job and trying to juggle stressful situation at home all the time with Michael and trying to be on the top of everything all of the time.”*

Although it was Rachel's decision to change jobs, as she repeated in the interview several times, she felt that she did not have any other choice. She accepted the reality of the situation, but felt that it was the price she had to pay for caring for her partner. Katy changed to flexible-working arrangements at work because, although her partner was supposed to take their son to school, she still felt that she needed to check every morning that this actually happened. This situation causes her stress on a daily basis. Mary, who had not been in paid employment for several years, claimed that the reason for this was bringing up her children,

but also that she could not leave the children with her partner. Also Carol, who used to do preparation for her work at home, had to introduce some practical changes which enabled to do her planning elsewhere. She said:

*“Paul’s mood swings are taking over my time that might then mean I won’t get that done that morning. And that just meant I had to change the way I work so I don’t work from home anymore which can be quite a pain. It costs me quite a fortune in coffee cause I go to coffee shops with free wi-fi and get my work done.”*

Carol’s space outside of the house became not only her workplace. In a sense, the coffee shop gave her a sense of stability and continuity, something she does not have at home. She knows what to expect from being there and this can be reassuring. Other participants, such as Rachel, Katy and Anna, would also consider their work as a place where they felt in touch with their true sense of identity, which they struggle to connect with at home. Mary and Tracey, who do not have paid work, needed to find their ‘safe haven’ elsewhere. For Mary it was the kitchen and for Tracey it was focusing on being a mum.

Carol and Rachel also referred to having some domestic arrangements, such as cleaning, washing or shopping, planned around their military partners. Rachel explained:

*“I try to encourage him to get out of the house as much as he can but he doesn’t like being crowded, he doesn’t like much noise so it’s kind of like right, we are going to go shopping at eight o’clock in the evening which isn’t the best time because that means that a half of the shelves are empty but that means that I will pop into the shop the next night.”*

Rachel’s arrangements regarding shopping create additional work for her, but she does not mind this as long as her actions have a positive impact on her partner’s well-being. This is, in

fact, always her priority, rather than thinking about having smaller work-load for herself.

Carol engages her partner in small tasks at home in order to build his confidence and giving their relationship a sense of normality and partnership, which is important for her. In contrast to Carol and Rachel, Mary, Anna and Katy do not tend to involve their military partners in domestic duties. Katy said that it is much easier for her to do housework herself as he finds it difficult and complains about it, which has negative impact on her. She said:

*“When I come back from work, I have to start making the dinner. He won’t peel the potatoes, he won’t sort anything out. He will collect my son from school and that’s it.”*

Mary and Anna did not even mention trying to get their partners to do anything, and this might be explained by the fact that doing domestic tasks serves them as a coping mechanism. Mary spends a lot of time in the kitchen cooking and baking and these tasks give her a sense of purpose and belonging. Anna does not mind going shopping, even at night, as she needs to keep herself constantly busy. Otherwise she becomes anxious and uneasy. She described this:

*“I sometimes go shopping at 11 o’clock at night just to, yeah, I usually say I was too busy to go earlier but I think sometimes it’s just because I just want to be busy because the busier I am then it is easier to sleep.”*

Participants needed also to re-organise their lives in terms of hobbies, social contacts and their self-care. Katy referred to having to stop attending ‘work dos’ and Mary to not having, until recently, any sociable contacts, even with her neighbours, due to worrying that it could potentially cause an argument. Also, for Rachel and Katy every activity which they do outside of their homes has to be carefully thought through. As a result, Rachel stopped going to the gym as she felt guilty about leaving her partner alone at home for too long. Instead, she

bought exercise machines and was exercising at home, which was another task she needed to find a solution for. She also does not socialise anymore:

*“I don’t socialise at all anymore because I’ve just, I think in the early days I used to let people down so much that I just stopped kind of saying “Yes” . I’ll just say “No, I won’t bother with that”. It doesn’t bother me. I am a homebody.”*

Katy, on the other hand, recently made a conscious effort to attend one fitness class per week, as she had put on weight within the last few years, something that her military partner also points out in their arguments. However, whenever she wants to leave the house to go to the class her partner claims that he cannot cope with looking after their primary school age son and he tries to stop her from leaving the house in different ways. Katy described one of those situations:

*“There’s always something that is going on. He’s burnt his hand while cooking pasta and he burnt his hand on the pan. I don’t know, I don’t know what happened. I couldn’t go to Boot Camp because of his injury and I didn’t know if he did this on purpose or whether it was truly an accident. I just feel he is trying to sabotage me leaving the home.”*

Katy thinks that her partner might have burnt himself on purpose. It might be that he wanted to make her feel guilty about leaving him behind or knew that she would have to stay in the house. According to Katy, he wants to isolate her from other people but it might be also that he is afraid that she will leave him.

Participants referred to changes within their roles in the relationships by describing themselves as their military partners’ parents and carers, rather than as their friends and

romantic partners. This was explicitly stated in Anna's, Carol's, Katy's and Tracey's interviews. Carol, for instance, said:

*“It sounds awful sometimes I do feel like I’m looking after a child. That kind of needy, like although he won’t directly ask me for it, it’s that reassurance he needs, that reassurance that he needs from me.”*

Participants tend to resent this role change as it reminds them that they do not share lives with equal partners but with someone they constantly need to look after. Katy explained:

*“He takes up so much time. It’s like I have another child in the house and that’s not what I wanted. I wanted a husband, a partner, a friend and that’s not what I’ve got.”*

Participants talked a lot about the way they manage and help their partners as if they were their carers, responsible both for their partners' emotional and physical well-being. Katy said:

*“I don’t feel like I’m his wife. I feel like I’m his carer. I might as well be a stranger doing washing, ironing, cooking and cleaning.”*

As a result of combining the role of a parent and a carer to their partners, participants use different practical and emotional strategies to fulfil their roles. If they do not - *“nothing is going to get sorted”* (Tracey, p.75). As a result, they validate and normalise their partners' feelings and reactions. Most of them have encouraged their partners to talk about their experiences and feelings as they believe that this will help them to stop sinking into low moods. Rachel and Carol motivate their partners to seek the support of their comrades and medical help. Rachel, Katy and Carol stimulate their partners to stay active by giving them certain responsibilities around the house. Carol introduced a diary to help her partner to remember things and Rachel arranges holidays around particularly difficult times of the year for her partner and waits for the right time to address certain issues with her partner. Rachel

also continuously tries to understand her partner's moods and behaviours and uses a mental "checklist" (p.109) to establish reasons for his moods, so that she can deal with them in a practical way. In fact, she referred to becoming "an expert" (p.107) in reading his body language, which suggests a high level of engagement and determination in understanding and helping her partner. Participants follow their instincts in choosing the right strategy and, as a result, not every strategy is always helpful as Rachel explained:

*"Sometimes it works sometimes he'll just tells us to fuck off and to leave him alone so... you just have to keep trying. Every now and again it gets very tiring so I stop trying for a few days, recover for a bit and I'll try again. And, I mean, it's literally like that where you just go up and down up and up and down and up and down."*

Rachel knows that finding the right strategy is a 'hit and miss' process but, instead of letting this get her down, this seems to motivate her to keep on looking for new ones. Carol also constantly tries out, with varying levels of success, various ways of managing her partner's negative behaviour, involving practical support or emotional reassurance. However, despite participants' determination and efforts, sometimes there is simply nothing they can do to make things better for their military partners. Tracy explained:

*"And when it's the bad days I just feel like I can't do anything. Because there is just nothing that can get him out of that frame of mind."*

This knowledge, together with constant efforts that participants make in dealing with and adapting to their partners' behaviours, makes them feel that they have reached their limit of being able to cope with things. As a result, some participants even talked about having thoughts of leaving their partners, although none of them intended to put this into practice. Talking about this possibility seemed to be more of an expression of how difficult things can be for participants and a way of reassuring themselves that there would be another option available to them should the home situation become impossible to cope with.

Moreover, all participants gave reasons for not leaving their partners, which were: being bound by their marriage oath, love for their partners, understanding that their partners are ill. Participants also seemed to have a sense of moral responsibility in helping their partners and Mary said that leaving him “*would be giving up too easy on him*” (p.11). Another significant reason was holding a conviction that if they left their partners – they would not cope on their own. One participant openly said that if she left her partner he would kill himself. As a result, no matter how exhausted emotionally and physically she might be, leaving her partner was out of the question. Instead, she would “*stop trying for a few days, recover for a bit and I’ll try again*” (Rachel, p.95).

#### **4.2.5.2 Discussion.**

Adapting to change can be understood as an adjustment to loss explained, to some extent, by the dual process model of coping with loss (Stroebe & Schut, 1999; 2010). This model focuses on loss-orientated but also on restoration-orientated aspects of grieving, which participants presented in, for instance, changing work and domestic arrangements or taking on new roles of parents and carers. However, rather than making the changes to improve their lives after experiencing loss, they made them, consciously or unconsciously, as a result of their particular home situations. Moreover, participants seemed to not be able to freely choose new restoration-orientated behaviours, but rather modify or cancel the existing ones. This happens because they did not experience actual, physical loss, which would create space in their lives which they could then fill in. Instead, they experience loss more in an emotional, quality-related sense, while remaining in the same relationships, which are at the centre of their losses. As a result, they adapt by creating more losses to their lives by giving up their hobbies, social lives or self-care, found also in another study (Kimhi & Doron, 2013), or make transformations to their work and domestic arrangements and their family roles.



PTSD has an impact on changes in partners' cognitive, biological, emotional and behavioural characteristics which consequently enforces, as mentioned by participants, certain marital adjustments and adaptations (Huston, 2000). This will consequently have an impact on each partner individually but also on the marriage as a union which can be perceived as a macroenvironment composed of partners' sociocultural environment and an ecological niche in which the couple is embedded. Although relationships change constantly, as well as partners themselves, PTSD imposes on participants certain changes in their beliefs and behaviours, which disrupt the eco-system of marriage. Changes in participants will have, consequently, an impact on their military partners, which reveals another way that primary trauma can be at the root of negative influence on partners.

Participants' most prominent adaptation to their life situations seems to be taking on new roles, and both 'adaptations' and 'roles' are reflected in couple's functioning components of the CATS model (Nelson Goff & Smith, 2005). Partners take on the roles of parents and carers, which supports findings from another qualitative study (Lyons, 2001) and this appears to be a natural response to seeing their military partners struggling with mental health, self-identity, social interactions, work but also daily tasks. This transition is confirmed in literature on caregivers to family members with chronic physical illnesses (Ress, O'Boyle & MacDonagh, 2001; Blum & Sherman, 2010) or mental health conditions (Shah, Wadoo & Latoo, 2010; Baronet, 1999). However, caring for family members, especially over long periods of time, can lead to 'caregiver's burden', which seems to be experienced, to differing extents, by all participants. Participants observed getting emotionally and physically tired with being responsible for most, if not all, day-to day responsibilities, arrangements and decision-making, which supports a finding of another study in which veterans' wives called their husbands "handicapped" in regards to family functioning (Kimhi & Doron, 2013, p.192). Moreover, they are tired with caring for their partners and being responsible for them

to the point of being in danger of burnout, which suggests that the ‘caregiver’s burden’ is another cost of ST. It can be seen, in fact, as an additional component, external to all others elements, in the CATS model (Nelson Goff & Smith, 2005). This component, although characteristic only for secondary victims of trauma, could have a reciprocal impact on primarily traumatized partners, such as a reduction in the levels of care and support that they receive.

Participants seemed to express the weight of their ‘caregiver’s burden’ by talking about their thoughts of leaving their military partners. Despite having these thoughts, they do not intend to put into practice, which was also found in other studies (Dekel et al., 2005; Kimhi & Doron, 2013). Participants would not leave their partners because they seem to adhere to self-assigned roles of wives or partners of someone with long term illness and/or partners of a military person. Moreover, the additional roles of parents and carers were imposed on them, on top of these self-assigned roles, causing at least some of the participants to feel trapped by even more responsibilities towards their partners.

Despite participants’ various struggles, they do not look after themselves physically and emotionally, although a few of them, the most resilient and confident ones, still fight for their separateness and independence. This was illustrated by, for example, having a job or trying to pursue some activities, such as going for a ‘work-out’. At the same time, these attempts of participants’ autonomy can enhance military partners’ fears of abandonment, especially for those with anxious attachment styles (Sherman et al., 2006) to which they might react with aggression and anger. This seems to be the case for the military partner who would burn his hand to stop his partner from going to the fitness class. Interestingly, insecure attachments can be also a predisposing factor for PTSD development. This is because attachments styles are responsible for how people react to stress and traumatic events (Scott & Babcock, 2010) which is dictated by their views of themselves and others. People with

insecure attachments and negative sense of self have more dysfunctional beliefs than others and have significant levels of self-blame (Muller, Kraftcheck & McLewin, 2004). Also, if they had parents who were fear-provoking or changeable, they might have developed malfunctioning cognitive processing which stops them from developing coping mechanisms from their life experiences (Muller et al., 2004). Insecure attachments are, however, only an example of predisposing factors in military partners' PTSD development. Other factors might be, for example, childhood adversity, severe accident, or combat exposure and lack of sense of comradeship (Goodwin & Rona, 2013). The important message that comes from this is that these predisposing factors can be rooted in early childhood or much later, such as during military partners' military service. They can also involve other people such as military partners' parents, people who might have abused them, their military commanders, etc. This is what makes PTSD complicated and confusing both for military partners and their partners.

#### **4.2.6 LONELINESS**

This theme relates mainly to the first research question, which asks about participants' experiences of living with their military partners. This is the final theme presented, as it provides a symbolic summary of participants' experiences in fighting a very lonely battle.

##### ***4.2.6.1 Findings.***

Participants often feel lonely as they have a limited number of people to talk to about their experiences, with their friendships having dwindled over the years. They also find it difficult talking to others about their experiences. Anna, for example, is ashamed that she allows her partner to treat her the way he does and Tracey is afraid that people would judge her and her partner, as they might think that a person with PTSD is always violent with their families. Rachel has not told anyone at work about her situation and has declined any form of help for herself, as she is worried that people would offer her sympathy which would be

disempowering for her and would take the focus away from helping her partner. For Katy, talking about her life to her family results in her feeling more pressurised to leave her partner, which adds to her confusion about how she feels about her partner. Carol cannot talk freely with her friends about certain things because of the military confidentiality they are bound to, particularly as her partner is still in active military service. Mary does not talk to others because she is afraid of her partner's jealousy. She said:

*“He thinks that if I speak to somebody else that's it I'll go off and leave him, which makes it difficult cause it gives me a limited number of people I can speak to. I am surprised he agreed to it (this interview) actually probably cause you are a woman.”*

There might be another reason for participants' reluctance to talk about their experiences with others, which was explicitly mentioned by Anna. Despite wanting to talk about their situation, Anna felt that talking about her partner in the interview was almost like betraying him. The notion of disloyalty was most likely influenced by the fact that, although partners had agreed to them taking part in the interviews, they had felt uncomfortable about it, as revealed by Carol, Katy and Rachel. Participants managed to negotiate this conflicting situation by saying that it was important for others to know how it is to live with someone with PTSD, and that they felt that by taking part in the interview they were helping others. At the same time, it became clear that most of participants had a need to talk about their experiences for themselves. For example, Mary confessed that the interview was her first chance in years to talk freely about her experiences in 10 years.

Another apparent cause of participants' loneliness is their belief that others would not understand their experiences of living with someone who has PTSD, because they sometimes do not understand these experiences themselves. Tracey explained:

*“I do understand PTSD but I don’t fully understand how Brian is feeling, what’s got him to this point, because they are the sort of things he won’t tell me. So it is guesswork for me, really, so trying to explain it to other people I find hard.”*

Moreover, Tracey seems to believe that only her mother, who lives with them, is able to understand it because she is experiencing it herself. Another participant, Anna, questioned even professional understandings of PTSD and its impact on the family:

*“I don’t know if people understand what PTSD is. I’m not sure if some of the professionals, really, understand the full impact of what’s going on. I think they see, I think a lot of people they see erm dramatization of it, you know, people hiding under the table when they hear a bang and that kind of thing and that’s just not right. I’m sure for some people it is but it’s not that direct.”*

Participants, such as Anna but also Rachel Carol and Tracey, were very clear about the fact that, although many people associate PTSD with flashback and nightmares, to them the biggest difficulties are day-to-day situations and the emotional impact of dealing with them. Moreover, none of the participants, apart from Rachel, had been encouraged to seek professional help. It was apparent that some participants felt that the professionals they had encountered tended to regard PTSD as an issue relating only to military partners. All participants also pointed out that their invitations to the research were the first sign of recognition of their experiences. Katy said:

*“Nobody has turned round, apart from yourself (and said) what about those who are left at home how are they surviving with this cause it’s quite easy for him to put a smile and tell everybody that it’s fine but when you get back at home it’s not. It can be quite traumatic itself and very stressful.”*

Katy made it clear that sharing a life with her partner who has PTSD is difficult and she sounded bitter when talking about the lack support for people in a similar situation to hers. She even called her experiences traumatic due to facing all the challenges on her own, without others realising how she is affected by her partner's moods and behaviours. Her partner reassuring others that he copes well seem to isolate Katy even more, as she knows that he displays his real behaviour and moods only at home, only to her.

Despite feeling lonely because of the fact that others would not or do not understand their experiences, the loneliest place for most participants seems to be their homes. Although military partners are present in the house, they often withdraw emotionally and physically from family life, leaving participants feeling almost abandoned. At the same time, because of their withdrawal, participants have the sole responsibility for keeping 'the family fire burning' which they do in emotional and practical ways, adding to their already overwhelming responsibilities. For example, it is Anna who made the effort of keeping in touch with her partner's daughter because she believes that if she had not, he would not have done that. Some participants noted that their partners did not even want to spend time in the same room or to have a conversation with them. Katy's partner refuses, for instance, to sit at the same table with her at dinner time:

*"He won't sit at the dinner table. He'll sit on his sofa and he'll have his meal so we don't sit and eat a meal together."*

She continued:

*"No speaking and then he'll put a plate in the kitchen and he will go upstairs to his room. And I'm just sat there. No friends. And I'd be just sat there on my own. He'll watch TV."*

This makes Katy feel depressed, abandoned and she goes to work “*to escape*” (p.119), which suggests how difficult she finds being at home, the place which should give her peace and comfort. Also, Anna’s, Mary’s and Katy’s partners spend much time in separate rooms and Anna explained:

*“He doesn’t like me really being with him cause he doesn’t like to talk. You can’t, you know, you can’t sit and watch telly and laugh and talk about it, you know like, like you would in some families.”*

Even the smallest parts of participants’ home lives are affected with their military partners’ moods and behaviours. This impact seems overwhelming.

#### **4.2.6.2 Discussion.**

Participants feel lonely at their homes due to their partners’ emotional withdrawal, which is a representation of avoidance and numbing symptoms of PTSD. Emotional withdrawal decreasing partners’ emotional disclosure (Campbell & Renshaw, 2013; Ray & Vanstone, 2009). This is understandable, because emotional withdrawal impairs communication, which is an important component of a couple’s functioning components of the CATS model (Nelson Goff & Smith, 2005). Lack of communication affects couples’ functioning and intimacy and deepens emotional distance between partners (Whiffen & Oliver, 2004). This happens because partners do not understand each other’s displayed emotions and interpretations of behaviours which, in the case of military partners’, might be acted out through aggression or withdrawal (Zayfert & DeViva, 2011).

Emotional withdrawal is not only difficult to deal with but has a negative impact on partners’ psychological stance and their relationship quality, especially for those with insecure attachments. In anxious attachment styles, a sense of ‘self’ is dependent on

acceptance and attention of others (Nicholls et al., 2014). If military partners remove themselves emotionally from participants with this particular attachment style, they might interpret this behaviour as a rejection. For participants with avoidant attachment styles, military partners' withdrawal might be a confirmation that they should be dismissive of others and not depending on anyone because they get hurt otherwise (Nicholls et al., 2014). Also, military partners' emotional withdrawal might intensify or maintain unconscious 'couple dances' such as 'the dance of distance' during which "one partner's withdrawal triggers a counterwithdrawal in the other, thus creating a vicious cycle of mutual withdrawal" (Middelberg, 2001, p.346). This gives another insight into the reciprocal impact of primary and secondary trauma.

Military partners' emotional avoidance might be experienced even more negatively by women who connect it to relationship dissatisfaction (Afifi et al., 2012). This might be explained by the fact that women tend to present greater emotional attunement than men (Lambert et al., 2012), making them more aware and sensitive to different emotions expressed (or not being expressed) by their partners. Furthermore, participants themselves tend to avoid communicating their thoughts and feelings about their partners' behaviours and moods in order not to upset them, or because they know that they would be dismissed. This creates a vicious cycle of miscommunication, where partners, instead of explaining things to each other, make assumptions which are not then challenged. This, consequently, leads to partners becoming even more emotionally disconnected.

Participants also feel lonely socially as many of their friendships have dwindled over the years or, they feel, their friends would not understand what they are going through. This is because participants find it impossible to explain to anyone the complexity of living with someone with PTSD. Moreover, some of the participants feel ashamed to give their friends a true description of their home experiences, as they believe that they will be judged or offered



sympathy. Finally, telling others the full extent of their experiences would mean admitting how affected they are with them. If they were to do this, however, a natural consequence could be that they would find possible solutions, such as receiving support for themselves. In order to feel able to reach out for support, however, participants would have to believe that they have a right to this support, and this seems to be the case for only two of them. This is quite understandable, because the experiences of partners of those with PTSD do not seem to be widely validated and recognised even by professionals with knowledge of PTSD. This was recognised by most of the participants.

## **CHAPTER 5 – GENERAL DISCUSSION, RECOMMENDATIONS, AND CONCLUSIONS**

In this chapter, a summary of study findings will be presented, followed by the implications of findings for future policy and practice. Also, study limitations will be described, together with suggestions for future research and an explanation of the importance of the study.

### **5.1 SUMMARY OF FINDINGS**

Qualitative semi-structured interviews, conducted using IPA methodology with six UK female participants living with military partners diagnosed with PTSD, confirm that living with military partners' PTSD is a source of distress for participants and negative relationship change, which requires constant management and which could be a source of ST. Six major themes emerged from the findings (see Table 1), which were: ongoing unpredictability of partners' moods and behaviours; hypervigilance; triggers for military partners' moods and behaviours; adaptations; loss and loneliness. All of these relate to the first research question: What are partners' experiences of living with military partners with PTSD? Three of the themes - hypervigilance; finding potential triggers for military partners' moods and behaviours; adaptations - relate to the second research question: How do partners cope with the impact of living with military partners with PTSD? Four of the themes - ongoing unpredictability of partners' moods and behaviours; hypervigilance; triggers for military partners' moods and behaviours; adaptations - relate to the final research question: Do partners living with military partners with PTSD experience ST and, if so, how is it represented?

#### **5.1.1 PARTNERS' EXPERIENCES**

The findings showed that participants experience the ongoing unpredictability of their military partners' changing moods and behaviours, which can take different forms and varies in terms of intensity. Some participants had even experienced emotional abuse and threats of physical aggression. This overshadows and dictates participants' lives, but also the lives of their children, suggesting that PTSD is a family condition. Continuous exposure to these moods and behaviours leads to partners being constantly hypervigilant- expecting the unexpected. Participants are also overwhelmed by practical and emotional responsibilities stemming from either supporting their military partners or taking over various responsibilities from them. This might lead to 'caregiver's burden' and, with time 'emotional burnout' and having thoughts of leaving their military partners. However, despite this, participants do not stop supporting them as they know that without them- military partners would not cope and some might even find themselves at risk to themselves. Moreover, due to changes in military partners as a result of their PTSD, all participants experience a sense of loss: of their partners for whom they are more like carers and parents, of romantic relationships with them and also of who they are. At the same time, however, one participant referred to gaining from being in the relationship with her military partner, which could be explained by the 'benefit finding' phenomenon. Losses leaves participants feeling lonely, which is aggravated by a lack of social support, which has dwindled as a result of their partners' PTSD and lack of understanding of their struggles by professionals and others.

### **5.1.2 COPING WITH THE IMPACT**

Participants coping mechanisms focus on predicting, minimising and de-escalating military partners' negative behaviours and moods. These are implemented on a 'hit and miss' basis as most participants lack professional and social support in dealing with their home situations. As a result, they continuously try to find potential triggers to military partners' moods and behaviours. This process resembles a vicious cycle, however, because as they

address certain triggers to their military partners behaviours, new triggers or unexplained behaviours appear in their place. Another coping mechanism is maintaining a hypervigilance state over what is safe for them to say or do at home. This enables them to implement carefully chosen and self-designed overt and covert strategies which allow them to manage, but only to a certain degree, home situations. The final major coping mechanism is making various adaptations, which were often enforced on participants because of their particular life circumstances. The adaptations involve partners' work and domestic arrangements, their social and personal lives and transformation of roles into caregivers and parents to their military partners.

### **5.1.3 SECONDARY TRAUMATIZATION**

The research findings suggest that participants might be traumatized as a result of their experiences of living with military partners diagnosed with PTSD. This could potentially be called ST because they are affected indirectly by their military partners' PTSD symptoms. Moreover, it is ongoing, prolonged exposure to PTSD cluster symptoms, mainly avoidance and increased arousal, which seems to be the crucial element of this traumatization. This challenges the assumptions that ST develops only as a result of having deep empathy for those with PTSD, wanting to help them and learning about their traumatic experience (Figley, 1995). Also, the research findings raise the question of whether military partners' disclosure is essential in ST development, as the study showed that even if military partners do not disclose their experiences, their partners have some sense of what happened to them. They also seem to be more traumatized through dealing military partners' unpredictability of moods and behaviours on a daily basis than with the traumatic event itself.

Moreover, although ST is believed to be characterised by the presence of observable, PTSD-like symptoms, study findings supported this only partially. Although all partners

presented PTSD symptoms, which was confirmed using the PCL-C screening tool, not all of these symptoms were revealed in their narratives. One of the explanations for this is that partners referred in their narratives only to those aspects of their situation that they found most difficult. Another explanation might be that people with ST might display some but not all PTSD symptoms.

## **5.2 IMPLICATIONS FOR FUTURE POLICIES AND CLINICAL PRACTICE**

### **5.2.1 RECOGNITION OF SECONDARY TRAUMATIZATION**

Persistent lack of professional validation and recognition of partners' experiences and, most importantly, how they have been affected by their military partners' PTSD, impairs, if not prevents, improvements occurring in partners' well-being. Without this recognition, they are likely to normalise and accept their negative experiences, as well as the feelings and thoughts attached to them, as normal. This might stop them from accessing any form of informal or formal support.

Recognising ST as a mental health condition or, at least, phenomenon, would raise awareness and recognition of partners' experiences among professionals, general public and also partners themselves. This would de-stigmatize partners' condition and could empower them to access help. Moreover, having more informed practitioners would have an immediate impact on the quality of support offered. For example, clinical practitioners, such as psychologists, would be able to incorporate notions of ST into their formulations of clients' issues and clinical interventions.

### **5.2.2 EARLY SUPPORT**

The findings from the study clearly showed a need for support to be made available to people living with military partners with PTSD. This should take different forms, such as

emotional support by offering psychological therapies or educational interventions in regards to information about PTSD and its implications for the military partners and their families. Educational interventions could be used as a prevention measure (for partners of currently or future serving military partners) and as a part of recovery processes. This could increase partners' understanding and recognition of PTSD and ST symptoms and relationship quality. Psychological support could help to prevent further development of these conditions and to initiate healing processes.

Support for partners should be available as soon as possible after military partners develop PTSD. This would prevent them from experiencing accumulative negative impacts of living with their military partners with PTSD and would stop “a gradual process of becoming enmeshed in the veteran’s pathology” (Lyons, 2001, p.75). The findings showed that although both partners with short and long relationship were traumatized or, at least, significantly affected, by their home experiences, those in longer relationships seemed to struggle more with self-esteem and confidence, but also with the “heavy burden” of caring (Dekel et al., 2005, p.34). Apart from one participant, those in longer relationships seemed to have less hope that things would improve. This might result in them not believing that support, even if it was available to them, would make any positive change to their life situation, and therefore not accessing it. Another reason for providing early support to partners is the fact that partners can have a significant impact on soldiers’ recovery (Buchanan et al., 2011). They are often their ‘primary caregivers’ (Dekel et al., 2005) and, for example, responsible for encouraging them to get professional support and for keeping up their medical appointments.

Also, failure to diagnose PTSD early enough can have a progressively negative impact both on military partners and their families, which could present bigger challenges in treatment. Moreover the importance of the right diagnosis and treatment is important not only

in regards to veterans and military personnel of most recent conflicts, but in regards to the future of the military, which by 2020 will have significantly greater reserve strength than at present (Transforming the British Army, 2013). Organisational changes in the UK military mean that more military personnel might be potentially at risk of developing PTSD in the future, as deployed reservists have a higher prevalence of PTSD when comparing to deployed soldiers (Fear, et al., 2010; Harvey et al., 2012).

### **5.2.3 RECOGNITION OF PTSD AS A FAMILY CONDITION AND ITS RECIPROCAL IMPACT**

The findings clearly showed that PTSD is a family condition as it affects military partners, their partners but also their children, who, as already suggested in other studies, could be victims of trans-generational transmission of trauma (Dinshtein et al., 2011; Yehuda et al., 1998). As a result, the whole family system should be considered when offering clinical help to those affected by PTSD, by offering systemic approaches to trauma treatment for PTSD and ST, such as the CATS (Nelson Goff & Smith, 2005).

The CATS seems to be clinically valuable as it appreciates, as strongly highlighted in this study, reciprocal processes taking place between partners who are influenced and influence each other's reactions to trauma. The study showed that adaptability, roles and communication were the most prevalent mechanisms of couple functioning, at least in regards to partners. However, it seems that what impairs couples' recovery is lack of communication and this should be one of the main focuses in couple's therapy. This would help to prevent further emotional detachment within relationships and would positively influence couples' functioning and intimacy (Whiffen & Oliver, 2004). This could result in couples being more open in communication of their thoughts and feelings. Moreover, these changes would enable safer conditions for military partners to disclose their traumatic

incidents (Balderrama-Durbin et al., 2013). Consequently, emotional disclosure and recurrent stimulation of trauma memory can facilitate natural recovery from PTSD (Foa, Hembree & Rothbaum, 2007) and in clinical treatments, such as prolonged exposure or cognitive therapy, is a condition to successful processing of trauma (Brewin, 2003).

### **5.3 LIMITATIONS OF THE STUDY**

This study has several limitations, including several relating to the participant sample. Firstly, the participants were self-selected, which may have skewed the findings. It is possible that other potential participants, who decided against taking part in the study, could have had very different experiences within their relationships.

Another sampling limitation relates to the lack of strict homogeneity, due to difficulties in recruitment. Participants varied in terms of age, having children and jobs, relationship status and length, and also whether their relationships started after or before their military partners developed PTSD. Moreover, some participants were partners of currently serving military personnel, whereas others were partners of veterans. However, it is believed that the participant sample was at least fairly homogeneous, which is what IPA researchers should strive for (Smith et al., 2009), as all participants were female and lived with their military partners, all of whom were diagnosed with PTSD, in stable relationships. Moreover, using the PCL-C questionnaire as a screening tool ensured that all participants taking part in the interviews presented PTSD-like symptoms. These factors enabled research questions to be meaningful to all participants and allowed me to draw common themes from their narratives. Also, thanks to differences within the participant sample the study provided an insight into partners' experiences at different stages of their relationships and timescales of their army PTSD.



Another limitation relates to the PCL-C questionnaire tool. Participants were recruited to semi-structured interviews on the grounds of achieving the cut-off score on the PCL-C questionnaire, which suggested that they had PTSD-like symptoms. However, the PCL-C does not provide information as to whether participants presented all symptom criteria expected in the *DSM-IV* (4<sup>th</sup> ed.; *DSM-IV*, American Psychiatric Association, 1994). It also does not measure specific traumatic events which lead to PTSD development. This means that participants' answers could relate to other traumatic incidents that had occurred in their lives, which could lead to misidentification of ST, a possibility also suggested in other studies (Renshaw et al., 2011; Melvin et al. 2012). However, the research interviews revealed that only one participant had a prior traumatic experience which was unrelated to her military partner's PTSD. Moreover, the PCL-C questionnaire is only a screening tool and should never stand for a comprehensive clinical diagnosis. However, establishing if participants have a clinical condition was never an aim of this study, which focused on exploration of partners' experiences and the possibility if these indicate the presence of ST.

Due to the fact that this was a qualitative study, based on a relatively small sample and using IPA, it did not produce nomothetic data that could not be used to build a new theory. However, the research findings may well have implications for wider populations of military partners, particularly in the UK context.

#### **5.4 SUGGESTIONS FOR FUTURE RESEARCH**

Future UK studies would benefit from being informed by participant recruitment difficulties that were experienced in this study and exploring more effective ways of recruiting participants. Instead of approaching charities and other organisations helping military personnel and their families, it might be more useful to have direct contact with gatekeepers such as Military Forces. This could also lead to a more homogeneous participant

sample, composed of either partners of veterans or military personnel (rather than both). Moreover, it would enable recruitment of male partners of military partners, who appear to be more difficult to reach out to due to the lower number of female military personnel. Including male partners would enable comparison between female and male experiences of living with someone with PTSD.

Additionally, the findings from this study could be used to inform a larger study in terms of sample size but also its scope. A future study could take the form of a longitudinal study, which would enrich insight into how experiences of partners of army personnel with PTSD changed over time. This would give further insight into ST development and maintenance. Moreover, in order to create an even more comprehensive picture of the impact of living with someone with PTSD and ST development, studies could involve not only partners but also children.

Future studies could also include the PCL-5 questionnaire as a screening tool, compatible with the newest *DSM* version (5<sup>th</sup> ed.; *DSM-5*, American Psychiatric Association, 2013). Another reason for this is that the PCL-5 seems more reliable than the PCL-C questionnaire in terms of establishing participants' potential PTSD (Weathers et al., 2013).

Future research on the impact of PTSD on partners in romantic relationships could also focus more closely on the presence of abuse in these relationships. Although various studies already acknowledged a high correlation between PTSD and violence (Angkaw et al., 2013; MacManus et al., 2012; Taft et al., 2011) future research could explore, in particular, how, if a relationship is controlling and abusive, partners manage this and what their reasons are for staying in these relationships. Possible reasons are: partners' life history, in particular being abused as a child or witnessing domestic violence in a family home, being financially dependable on their abusive partners or being highly committed and having certain rigorous values and traditions and feeling that they have invested a lot in the relationship (Anderson &

Saunders, 2003). Abused partners might also apply certain coping, cognitive strategies which allow them to see their relationships as more positive, although this becomes more difficult in the case of verbal abuse (Herbert, Silver & Ellard, 1991). Partners might also want to stay in their relationships because of their insecure attachments (Scott & Babcock, 2010) or the phenomenon of ‘traumatic bonding’ which is characterised by developing certain emotional, negative attachment patterns with an abusive partner and which correlates with low self-esteem of abused partners (Dutton & Painter, 1993). Another set of reasons might stem from a full understanding of coercive control, which is characterised by not only violent behaviour but isolation or intimidation, and where an abusive partner might exploit partners’ predisposing vulnerabilities such as abuse in childhood (Dutton & Goodman, 2005). Although only a few potential reasons for staying in abusive relationships have been mentioned, there is a substantial amount of literature in that field could signpost future research on partners’ experiences of living not only in an abusive relationship but with someone with PTSD. Future research could investigate if partners would have similar reasons for staying in relationships and what, in particular, helps and hinders this process.

## **5.5 CONCLUSIONS - SIGNIFICANCE OF THE STUDY**

This study contributes to our understanding of this topic by providing in-depth descriptions and interpretations of the experiences of participants’ experiences of living with military partners with PTSD. This was enabled by using a qualitative and idiographic research approach, which is not commonly used in relation to this topic and which adds richness to the research data. Also, to the best knowledge of the researcher, this study was the first UK project focusing only on partners’ experiences of PTSD.

The research findings revealed significant difficulties that partners and their children face when sharing their lives with military personnel or veterans with PTSD. They also

highlighted a staggering lack of formal or informal support available to partners, and a lack of validation of their struggles, which makes them the ‘forgotten victims’ of military-related PTSD. The study aimed to address this by giving participants a voice in the research, but also by raising a discussion about partners’ potential ST. As the possible existence of ST was critically evaluated in the light of the research findings, this has the potential to enrich understanding of this concept, thereby informing future policy and clinical practice.

The study also provided further evidence of how damaging untreated PTSD can be, both for military partners and all family members living with them. This suggests that PTSD should be perceived as a family condition.

## CHAPTER 6 – CRITICAL REVIEW

In this chapter my reflections on the research process will be presented.

### 6.1 REFLECTIONS ON THE RESEARCH PROCESS

I entered the research process considering myself more as a participants' advocate than a neutral researcher. I felt a sense of injustice concerning UK partners of military personnel with PTSD, because of the lack of recognition of their struggles and experiences in media and in research, but also the lack of support available to them from charities and other organisations. This attitude was reinforced in the first interview, when I was told by the participant that I was the first person in whom she had confided in 10 years. Other participants also mentioned that the interview was the first sign of anyone being interested in their experiences. Hearing this made me feel extremely privileged and humble, but also angry that, for so long, they had not received adequate support. As a result, I felt responsible for 'unsilencing' and validating participants' experiences and letting their stories be truly heard, which became my motivation to continue and complete the project. This also made the project much more meaningful because, from the moment I interviewed my first participant, it felt that I was also doing research *for* my participants. I felt I was unsilencing them at personal level.

Using IPA qualitative methodology, with semi-structured in-depth interviews as the main methodological instrument, enabled me to fully appreciate participants' uniqueness and individuality, by focusing closely on the details of their experiences. It also reinforced for me, as the researcher, the importance of being guided by participants' experiences and emotional reactions during interviews, rather than by my own agenda or strictly applied interview schedule. I valued this participant-led approach because it reflected the way that I see clients

in my counselling psychology practice- as them being experts on themselves and me, as a therapist, facilitating their realisation of this.

Another aspect of my professional background as a Counselling Psychologist Trainee which, in my opinion, made the research process a more empowering experience for participants, was using counselling skills. These allowed me to prompt participants to open up about their experiences but also to contain their strong emotional reactions. Additionally, being aware of power imbalances which might exist in a counselling relationship, I made particular efforts to sustain a sense of equality between myself and the participants. At every stage of the research process I tried to show participants my respect and gratitude to them for sharing their experiences. This was particularly important as I was aware how sensitive the topic was for them, and how difficult it must have been for some of them to open up to a stranger after years of silence.

However, although being a Counselling Psychologist ensured attending to participants' well-being and enhanced depth of data (Morrow, 2007), it also created a personal dilemma. I found it difficult to utilise my therapeutic skills yet remain within the research role, rather than being a therapist. In fact, on occasion, I wanted to counsel participants, or, at least, to openly encourage them to have counselling. I managed this conflict, although with some difficulty, by being self-reflective and constantly reminding myself about my particular role as a researcher. I also hoped that the positive interviewing experience would, in itself, encourage them to consider accessing support.

Another ethical consideration involved participants' safety, due to their military partners' unpredictable behaviours and short tempers. As a result, I decided not to reveal in my analysis of findings certain comments which, even if reported anonymously, could potentially put some participants at risk at home. These decisions were made after realising

that all participants' partners were aware of the study. Some of them had even asked participants what they talked about, or would talk about, during the study. Moreover, in two cases, it was, in fact, military partners who contacted me first to inform that their partners would be interested in the study.

Although only one participant said openly that she felt that she was betraying her partner by talking about him in the interview, this particular discomfort seemed to be present in most interviews. This is also supported by participants' comments about their reasons for taking part in the study, as most of them said that they wanted to make others aware how it is to live with someone with PTSD. It almost felt as if they did not think they deserved to be listened to and appreciated for their own individual experiences and that they needed to have a greater reason to talk about them. This only proves how little recognition there is, even among partners themselves, of their right to self-validation, self-care but also to have access to support which would focus on their struggles and needs. This would also explain the fact that, even after advertising the study through six organisations, it took eight months for eight participants to express their interest in taking part.

## **6.2 REFLECTIONS ON MY SELF-DEVELOPMENT**

The research project pushed me outside of my comfort zone personally and professionally. This was one of the most difficult experiences during the whole professional doctorate programme as it required not only the ability to fulfil the dual roles of a scientist practitioner and a reflective practitioner, but also self-belief in my professional skills and abilities. At the same time, I can honestly say that this was one of the most rewarding tasks that I have completed, allowing me to develop professionally and personally.

The research experience enabled me to incorporate into my counselling psychology practice more holistic therapeutic approaches to formulating clients' issues, taking into

account the environmental context of their struggles. It also allowed me to reflect on the use of integrative approaches to couple therapy. Although discussing similar issues, each participant and each described relationship was distinctively different. As a result, although therapies with each participant and their partners would have the same goal and lower grade interventions would precede applications of high order interventions, they would require different interventions to achieve this. Also, there would be a different focus in therapeutic work with each couple, with more attention being paid to, for example, challenging malfunctioning relational schemas or eliciting emotional awareness (Snyder & Balderrama-Durbin, 2012). My role in conducting this study has strengthened my belief in the value of providing clients with integrative models of therapy which would be suited to partners' personal characteristics and relationship difficulties embedded in particular contexts. The pluralistic approach provides an opportunity to do exactly this, in which an overall conceptualization of clients' issues and therapeutic interventions are continuously "matched to both therapist and client characteristics *in the moment*" (Snyder & Balderrama-Durbin, 2012, p.17)

Moreover, the IPA condition of being a reflective researcher enhanced the quality of the study and interpretation of its findings, and also resulted in me becoming a more self-aware practitioner and researcher. The project was the next stage in my ongoing self-development, which informs my professional conduct and lays foundations for my ethical practice (BPS, 2009). It also enabled me to consolidate further my professional competences as a future Counselling Psychologist (BPS, undated) which were reflected during the whole research process in attending to obligations and responsibilities towards myself and research participants. Examples of this include being respectful towards participants' beliefs and autonomy and conducting research within the scope of my abilities, as well as adhering to



confidentiality limits within the research process. This all enabled me also to achieve a higher standard of competence in my project.

Additionally, the research process allowed me to fully appreciate reciprocal effects of being a scientist and reflective practitioner, which complemented and enriched one another. This merging of roles consolidated my sense of identity as a future Counselling Psychologist, as it reassured me that I could see myself in the same ranks as psychologists of other branches of applied science.

The research process has also been hugely empowering on a personal level. It has enabled me to overcome self-doubts around being able to conduct research at doctorate level. I am glad that I persevered with the “research journey” because, although it was challenging at times, it allowed me to discover a part of myself which I would not have discovered otherwise. Different stages of research project completion made me realise that I have deeper levels of self-determination, motivation and perseverance than I thought I had. This came to light especially in problematic situations, such as struggles with obtaining ethical approval or difficulties with participant recruitment.

Also, to my surprise, the research process gave me an enormous sense of satisfaction and pride, particularly when transcribing interviews and realising how rich the data was. Most importantly, the content of the interviews confirmed that my choice of research topic was fully justified, as it revealed a clear need for attention and discussion among professionals providing help and support to military personnel and their families. In order to disseminate my findings to a wider audience, research findings will be shared with organisations and charities that assisted in participants’ recruitment. Moreover, my intention is to publish the findings in an academic journal, in order to inform the understanding and

practice of counselling psychologists working with military populations, but also working systemically with whole families where there is a diagnosis of PTSD.

## References

- Afifi, T.D., Joseph, A. & Aldeis, D. (2012). The “standards for openness hypothesis”: why women find (conflict) avoidance more dissatisfying than men. *Journal of Social and Personal Relationships, 29*(1), 102-125. doi:10.1177/0265407511420193
- Ahmadi, K., Azampoor-Afshar, S., Karami, G. & Mokhitari, A. (2011).The association of veterans’ PTSD with secondary trauma stress among veterans’ spouses. *Journal of aggression, Maltreatment and Trauma, 20*(6), 636-644. doi:10.1080/10926771.2011.595761
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4<sup>th</sup> ed.). doi:10.1176/appi.books.9780890423349
- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5<sup>th</sup> ed.). doi.org/10.1176/appi.books.9780890425596
- Anderson , D.K. & Saunders, D.G. (2003). Leaving an abusive partner. An empirical review of predictors, the process of leaving, and psychological well-being. *Trauma, violence, & abuse, 4*(2), 163-191.doi: 10.1177/1524838002250769
- Angkaw, A.C., Ross, B.S., Pittman, J.O.E., Kelada, A.M.Y, Valencerina, M.A.M., Baker, D.G. (2013). Post-traumatic stress disorder, depression, and aggression in OEF/OIF veterans. *Military Medicine, 178*(10), 1044-1050. doi: 10.7205/MILMED-D-13-00061
- Antony, M.M., Orsillo, S.M., Roemer, L. (Eds.), (2001). *Practitioner’s Guide to Empirically Based Measures of Anxiety*. New York: Kluwer Academic/Plenum Publishers.

- Ashworth, P. (2008). Conceptual foundations of Qualitative Psychology. In Smith, J.A. (Ed.), *Qualitative Psychology. A practical guide to research methods* (2<sup>nd</sup> ed., pp. 4-26). London, California, New Delhi, Singapore: Sage Publications Ltd .
- Australian Centre for Posttraumatic Mental Health. ( 2007). Australian guidelines for the treatment of adults with Acute Stress Disorder and Posttraumatic Stress Disorder. Practitioners' guide. Retrieved from [http://www.nhmrc.gov.au/\\_files\\_nhmrc/publications/attachments/mh15.pdf%20](http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/mh15.pdf%20)
- Australian Centre for Posttraumatic Mental Health. (2012). Summary of the military and veteran mental health and traumatic stress literature:2011. Retrieved from <https://phoenixaustralia.org/wp-content/uploads/2015/03/ACPMH-2011-MMH-Literature-Review.pdf>
- Australian Centre for Posttraumatic Mental Health. (2014). Military and veteran mental health literature scan: 2013. Retrieved from: <https://phoenixaustralia.org/wp-content/uploads/2015/03/ACPMH-2013-MMH-Literature-Review.pdf>
- Baird, K. & Kracen, A.C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly*, 19(2), 181–188. doi:10.1080/09515070600811899
- Balderrama-Durbin, Ch., Snyder D.K., Cigrang, J., Talcott, G.W., Tatum, J., Baker, M., Cassidy, D., Sonnek, S., Heyman, R.E, Smith Slep, A.M. (2013). Combat disclosure in intimate relationships: mediating the impact of partner support on posttraumatic stress. *Journal of Family Psychology*, 27(4), 560-568. doi: 10.1037/a0033412
- Baronet, A.M. (1999). Factors associated with caregiver burden in mental illness: a critical review of the research literature. *Clinical Psychology Review*, 19(7), 819-841.

- Basham, K. (2008). Homecoming as safe haven or the new front: attachment and detachment in military couples. *Clinical Social Work Journal* 36, 83-96. Retrieved from: <http://link.springer.com/article/10.1007%2Fs10615-007-0138-9#page-1>
- Baum, N. (2014). Female receptivity and secondary traumatization in the family. *Family Process*, 53(2), 225-238. doi: 10.1111/famp.12049
- Bastawrous, M. (2013). Caregiver burden- a critical discussion. *International Journal of Nursing Studies*, 50(3), 421-441. doi: 10.1016/j.ijnurstu.2012.10.005
- Biddle, D., Elliott P., Creamer, M. Forbes, D. & Devilly, G.J. (2002). Self-reported problems: a comparison between PTSD diagnosed veterans, their spouses, and clinicians. *Behaviour Research and Therapy*, 40(7), 853-865. doi:10.1016/S0005-7967(01)00084-5
- Bliese, P.D., Wright, K.M., Adler, A.B., Cabrera, O., Castro, C.A. & Hoge, C.W. (2008). Validating the primary care Posttraumatic Stress Disorder screen and the Posttraumatic Stress Disorder checklist with soldiers returning from combat. *Journal of Consulting and Clinical Psychology*, 76(2), 272-281. doi: 10.1037/0022-006X.76.2.272
- Blum, K. & Sherman, D.W. (2010). Understanding the experience of caregivers: a focus on transitions. *Seminars in Oncology Nursing*, 26(4), 243-258. doi: 10.1016/j.soncn.2010.08.005
- Bower, J.E., Low, C.A., Moskowitz, J.T., Sepah, S. & Epel, E. (2008). Benefit finding and physical health: positive psychological changes and enhanced allostasis. *Social and Personality Psychology Compass*, 2(1), 223-244. doi:10.1111/j.1751-9004.2007.00038.x

- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. Retrieved from: [http://eprints.uwe.ac.uk/11735/2/thematic\\_analysis\\_revised...](http://eprints.uwe.ac.uk/11735/2/thematic_analysis_revised...)
- Brewin, Ch.R. (2003). Post-traumatic stress disorder. Malady of myth? New Haven & London: Yale University Press.
- Browne , T., Hull, N., Horn ,O., Jones, M., Murphy, D., Fear ,N.T., Greenberg, N., French, C., Rona, R.J., Wessely, S. & Hotopf, M. (2007). Explanations for the increase on mental health problems in UK reserve forces who have served in Iraq. *The British Journal of Psychiatry*, 190 (6), 484-489. doi: 10.1192/bjp.bp.106.030544
- The British Psychological Society (2009). *Code of Ethics and Conduct*. Leicester: The British Psychological Society.
- The British Psychological Society (undated). *Professional Practice Guidelines for Counselling Psychologists*. Leicester: The British Psychological Society.
- Buchanan, C., Kemppainen, J., Smith, S., MacKain, S. & Wilson Cox, C. (2011). Awareness of posttraumatic stress disorder in veterans: A female spouse/intimate partner perspective. *Military Medicine*, 176(7), 743-751. <http://dx.doi.org/10.7205/MILMED-D-10-00378>
- Calhoun, P.S., Beckham, J.C. & Bosworth, H.B., (2002). Caregiver burden and psychological distress in partners of veterans with chronic posttraumatic stress disorder. *Journal of Traumatic Stress*, 15(3), 205-212.
- Campbell, S. B. & Renshaw, K. D. (2013). PTSD symptoms, disclosure, and relationship distress: Explorations of mediation and associations over time. *Journal of Anxiety Disorders*, 27(5), 494-502. doi: 10.1016/j.janxdis.2013.06.007

- Caspi, Y., Slobodin, O., Kammerer, N., Enosh, G., Shorer, S. Klein, E. (2010). Bedouin wives on the home front: living with men serving in the Israel Defence Force. *Journal of Traumatic Stress, 23*(6), 682-690. doi:10.1002/jts.20581
- Cassidy, T. (2013). Benefit finding through caring: the cancer caregiver experience. *Psychology & Health, 28*(3), 250-266. doi: 10.1080/08870446.2012.717623
- Catherall, D.R. (2004). Handbook of stress, trauma, and the family. New York, Hove: Brunner-Routledge.
- Cutts, L. (2011). Integration in counselling psychology: To what purpose? *Counselling Psychology Review, 26*(2), 38-49.
- Davis, J., Ward, D.B. & Storm, Ch. (2011). The unsilencing of military wives: wartime deployment experiences and citizen responsibility. *Journal of Marital & Family Therapy, 37*(1), 51-63. doi: 10.1111/j.1752-0606.2009.00154.x
- De Burgh, H.T., White, C.J., Fear, N.T. & Iversen, A.C. (2011). The impact of deployment to Iraq or Afghanistan on partners and wives of military personnel. *International Review of Psychiatry, 23*(2), 192-200. doi: 10.3109/09540261.2011.560144
- Dekel, R., Goldblatt, H., Keidar, M., Solomon Z. & Polliack, M. (2005). Being a wife of veterans with posttraumatic stress disorder. *Family Relations, 54*(1), 24-36. doi:10.1111/j.0197-6664.2005.00003.x
- Dekel, R. & Monson, C.M. (2010). Military related post-traumatic stress disorder and family relations: Current knowledge and future directions. *Aggression and Violent Behavior, 15*(4), 303-309. doi:10.1016/j.avb.2010.03.001

- Dekel, R. & Solomon, Z. (2006). Secondary traumatization among wives of Israeli POWs: the role of POWs' distress. *Social Psychiatry Epidemiology*, 4(1), 27-33. doi:10.1007/s00127-005-0002-6
- Dent-Brown K. (2010). *An Evaluation of Six Community Mental Health Pilots for Veterans of Armed Forces*. A Report for the Ministry of Defence. The University of Sheffield. Retrieved from: [http://www.sheffield.ac.uk/polopoly\\_fs/1.120472!/file/Sheffield-evaluation-published-version-15-Dec-2010.pdf](http://www.sheffield.ac.uk/polopoly_fs/1.120472!/file/Sheffield-evaluation-published-version-15-Dec-2010.pdf)
- DeVries, M.R., Hughes, H.K., Watson, H. & Moore, B.A. (2012). Understanding the military culture. In B.A. Moore (Ed.), *Handbook of counselling military couples* (pp. 7-19). New York, Hove: Routledge.
- Dinshtein, Y., Dekel, R. & Polliack, M. (2011). Secondary traumatization among adult children of PTSD veterans: the role of mother-child relationship. *Journal of Family Social Work*, 14(2), 109-124. doi:10.1080/10522158.2011.544021
- Dirkzwanger, A. J. E., Bramsen, I., Ader, H.& van der Ploeg, H. M. (2005). Secondary traumatization in partners of Dutch peacekeeping soldiers. *Journal of Family Psychology*, 19(2), 217-226. doi:10.1037/0893-3200.19.2.217
- Dutton, D.G. & Painter, S. (1993). Emotional attachments in abusive relationships: a test of traumatic bonding theory. *Violence and Victims*, 8(2), 105-120. Retrieved from: [https://www.researchgate.net/publication/15006319\\_Emotional\\_attachments\\_in\\_abusive\\_relationships\\_A\\_test\\_of\\_traumatic\\_bonding\\_theory\\_Violence\\_and\\_Victims\\_8\\_10](https://www.researchgate.net/publication/15006319_Emotional_attachments_in_abusive_relationships_A_test_of_traumatic_bonding_theory_Violence_and_Victims_8_10) 5-120
- Dutton, M.A. & Goodman, L.A.(2005). Coercion in intimate partner violence: toward a new conceptualization. *Sex Roles*, 52(11), 743-756. doi: 10.1007/s11199-005-4196-6



- Evans, L., McHugh, T., Hopwood, M. & Watt, C. (2003). Chronic posttraumatic stress disorder and family functioning of Vietnam veterans' and their partners. *Australian and New Zealand Journal of Psychiatry*, 37(6), 765-772. Retrieved from: <https://msrc.fsu.edu/system/files/Evans%20et%20al%202003%20Chronic%20posttraumatic%20stress%20disorder%20and%20family%20functioning%20of%20Vietnam%20veterans%20and%20their%20partners.pdf>
- Elwood, L. S., Mott, J., Lohr, J.M.& Galovski, T.E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review*. 31(1), 25-36. doi: 10.1016/j.cpr.2010.09.004.
- Elwood, L.S. & Williams, N.L. (2007). PTSD-related cognitions and romantic attachment style as moderators of psychological symptoms in victims of interpersonal trauma. *Journal of Social and Clinical Psychology*, 26(10), 1189-1209. doi: 10.1521/jscp.2007.26.10.1189
- Fear, N.T., Jones, M., Murphy, D., Hull, L., Iversen, A.C., Coker, B., Machell, L., Sundin, J., Woodhead, Ch, Jones, N., Greenberg, N., Landau, S. Dandeker, CH., Rona, R.J., Hotopf, M. & Wessely, S. (2010). What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. *Lancet*, 37(9728), 1783-1797. [http://dx.doi.org/10.1016/S0140-6736\(10\)60672-1](http://dx.doi.org/10.1016/S0140-6736(10)60672-1)
- Figley, Ch.R. (Ed.) (1995). *Compassion fatigue. Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York & London: Brunner-Routledge.

- Fikretoglu, D. & Liu, A. (2012). Prevalence, correlates, and clinical features of delayed-onset posttraumatic stress disorder in a nationally representative military sample. *Social Psychiatry and Psychiatric Epidemiology*, 47(8), 1359-1366. doi: 10.1007/s00127-011-0444-y
- Foa, E.B., Hembree, E.A. & Rothbaum, B.O. (2007). *Prolonged exposure therapy for PTSD. emotional processing of traumatic experiences. Therapist guide*. New York: Oxford University Press.
- Forbes, D., Creamer, M. & Biddle, D. (2001). The validity of the PTSD checklist as a measure of symptomatic change in combat related PTSD. *Behaviour Research and Therapy*, 39(8), 977-986. doi:10.1016/S0005-7967(00)00084-X
- Forbes, H.J., Fear, N.T., Iversen, A. & Dandeker, Ch. (2011). The mental health of UK armed forces personnel. The impact of Iraq and Afghanistan. *The RUSI Journal*, 156(2), 14-20. Retrieved from: <http://www.kcl.ac.uk/kcmhr/publications/assetfiles/iraqafghan/Forbes2011-mentalhealthUKarmedforces.pdf>
- Francickovic, T., Stevanovic, A., Jelusic, I., Roganovic, B., Klaric, M. & Grkovic, J. (2007). Secondary traumatization of wives of war veterans with posttraumatic stress disorder. *Croatian Medical Journal*, 48(2), 177-184. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2080512/>
- Galovski, T. & Lyons, J.A. (2004). Psychological sequelae of combat violence : a review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior*, 9(5), 477-501. [http://dx.doi.org/10.1016/S1359-1789\(03\)00045-4](http://dx.doi.org/10.1016/S1359-1789(03)00045-4)

- Gilbert, K. (1998). Understanding the Secondary Traumatic Stress of spouses. In Ch.R. Figley (Ed.), *Burnout in families. The systemic costs of caring* (pp.47-75). Boca Raton, London, New York, Washington: CRS Press.
- Goff, B.S.N. & Smith, D.S. (2005). Systemic traumatic stress: the couple adaptation to traumatic stress model. *Journal of Marital and Family Therapy*, 31(2), 145-157. doi:10.1111/j.1752-0606.2005.tb01552.x
- Goodwin, L. & Rona, R.J. (2013). PTSD in the armed forces: what have we learned from recent cohort studies of Iraq/Afghanistan? *Journal of Mental Health*, 22(5), 397–401. doi: 10.3109/09638237.2013.819422
- Gurman, A.S. (Ed) (2008). *Clinical Handbook of Couple Therapy* (4<sup>th</sup>Ed). New York; London: The Guilford Press.
- Hamilton, S., Nelson Goff, B.S., Crow, J.R. & Reisbig, A.M.J. (2009), Primary trauma of female partners in a military sample: individual symptoms and relationship satisfaction. *The American Journal of Family Therapy*, 37(4), 336-356. doi:10.1080/01926180802529965
- Harrison, K. (2013). Counselling psychology and power: Considering therapy and beyond. *Counselling Psychology Review*, 28(2), 107-118.
- Harvey, S.B., Hatch, S.L., Jones, M., Hull, L., Jones, N., Greenberg, N., Dandeker, Ch., Fear, N.T. & Wessely, S. (2012). The long-term consequences of military deployment: A 5-Year Cohort Study of United Kingdom Reservists Deployed to Iraq in 2003. *American Journal of Epidemiology*, 176(12), 1177-1184. doi: 10.1093/aje/kws248.
- Hayes, N. (2000). *Doing psychological research. Gathering and analysing data*. Buckingham, Philadelphia: Open University Press.

- Herbert, T. B., Silver, R.C. & Ellard, J.H. (1991). Coping with an abusive relationship: I. How and why do women stay? *Journal of Marriage and Family*, 53(2), 311-325.  
Retrieved from:  
<https://webfiles.uci.edu/rsilver/Herbert,%20Silver,%20&%20Ellard,%201991.pdf>
- Hinojosa, R., Hijonosa, M.S., & Hognas, R.S. (2012). Problems with veteran-family communication during operation Enduring Freedom/Operation Iraqi Freedom military deployment. *Military Medicine*, 177(2), 191-197. Retrieved from:  
<http://publications.amsus.org/doi/pdf/10.7205/MILMED-D-10-00385>
- Hoge, Ch.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I. & Koffman, R.L., (2004). Combat duty in Iraq and Afghanistan, Mental health problems, and barriers to care. *The New England Journal of Medicine*, 351(1), 13-22. doi: 10.1056/NEJMoa040603
- van Hoorn, L.A., Jones, N., Busuttil, W., Fear, N.T., Wessely, S., Hunt, E. & Greenberg, N. (2013). Iraq and Afghanistan veteran presentations to Combat Stress, since 2003. *Occupational Medicine*, 63(3), 238-241. doi: 10.1093/occmed/kqt017.
- Hopper, D. & Dryden, W. (Eds) (1991). *Couple therapy: a handbook*. Buckingham; Bristol: Open University Press.
- Hotopf, M., Hull, L., Fear, N.T., Browne, T., Horn, O., Iversen, AM., Jones, M., Murphy, D., Bland, D., Earnshaw, M., Greenberg, N. (2006). The health of UK military personnel who deployed to the 2003 Iraq war: a cohort study. *Lancet*, 367(9524), 1731-1741. doi: [http://dx.doi.org/10.1016/S0140-6736\(06\)68662-5](http://dx.doi.org/10.1016/S0140-6736(06)68662-5)
- Huston, T.L. (2000). The social ecology of marriage and other intimate unions. *Journal of Marriage and Family*, 62(2), 298-320. doi: 10.1111/j.1741-3737.2000.00298.x

- Iversen, A.I. & Greenberg, N. (2009). Mental health of regular and reserve military veterans. *Advances in psychiatric treatment*, 15, 100-106. doi: 10.1192/apt.bp.107.004713
- Iversen, A.C., van Staden, L. Hughes, J.H. Browne, T., Hull, L., Hall, J., Greenberg, N. Rona, R.J., Hotopf, M., Wessely, S. & Fear, N.T. (2009). The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study. *BioMed Central Psychiatry*, 9(68). doi: 10.1186/1471-244X-9-68.
- Jakupcak, M., Cook, J, Imel, Z., Fontana, A., Rosenheck, R. & McFall, M. (2009). Posttraumatic stress disorder as a risk factor for suicidal ideation in Iraq and Afghanistan War veterans. *Journal of Traumatic Stress*, 22(4), 303-306. doi: 10.1002/jts.20423.
- Jenkins, S.R. & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: a validation study. *Journal of Traumatic Stress*, 15(1), 423-432. doi:10.1023/A:1020193526843
- Jones, M., Sundin, J., Goodwin, L., Hull, L., Fear, N.T, Wessely, S., Rona, R.J. (2012). What explains post-traumatic stress disorder (PTSD) in UK service personnel: deployment or something else? *Psychological Medicine*, 43(8), 1703-1712. doi: 10.1017/S0033291712002619
- Jones, N., Mitchell, P., Clack, J., Fertout, M., Fear, N.T., Wessely, S., & Greenberg, N. (2014). Mental health and psychological support in UK armed forces personnel deployed to Afghanistan in 2010 and 2011. *The British Journal of Psychiatry*, 204(2), 157-162. doi: 10.1192/bjp.bp.113.131433
- Jordan, K., Marmar, CH.R., Fairbank, J.A., Schlenger, W.E., Kulka, R.A., Hough, R.L. & Weiss, D.S. (1992). Problems in families of male Vietnam veterans with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 60(6), 916-926.

Retrieved

from:<http://people.ucsc.edu/~cdobkin/Classes/Reza/Problems%20in%20Families%20of%20Male%20Vietnam%20Veterans%20with%20Posttraumatic%20Stress%20Disorder%20%28Jordan%29.pdf>

Kanno, H. (2010). Supporting indirectly traumatized populations: the need to assess secondary traumatic stress for helping professionals in DSM-V. *Health & Social Work, 35*(3), 225-227. doi:10.1093/hsw/35.3.225

Karney, B.R. & Crown, J.S. (2007). *Families under stress. an assessment of data, theory, and research on marriage and divorce in the military*. Santa Monica, Arlington, Pittsburgh. RAND National Defense Research Institute. Retrieved from: <http://www.rand.org/pubs/monographs/MG599.html>

Keeling, M.E. (2014). *UK military personnel and their romantic relationships: the impact of the recent conflict Iraq and Afghanistan*. Ph.D. Thesis, Kings' College. Retrieved from: [https://kclpure.kcl.ac.uk/portal/files/12790551/Studentthesis-Mary\\_Keeling\\_2014.pdf](https://kclpure.kcl.ac.uk/portal/files/12790551/Studentthesis-Mary_Keeling_2014.pdf)

Keen, S.M., Kutter, C.J., Niles, B.L & Krinsley, K.E. (2008). Psychometric properties of PTSD checklist in sample of male veterans. *Journal of Rehabilitation Research & Development, 45*(3), 465-474. Retrieved from: <http://www.rehab.research.va.gov/jour/08/45/3/pdf/keen.pdf>

Kerr, M. E. (2000). One family's story: a primer on Bowen theory. *The Bowen Center for the Study of the Family*. Retrieved from: <https://www.thebowencenter.org/theory/>

Kim, Y., Carver, Ch.S., Schulz, R., Lucette, A. & Cannady, R.S. (2013). Finding benefit in bereavement among family cancer caregivers. *Journal of Palliative Medicine, 16*(9), 1040-1047. doi: 10.1089/jpm.2013.0049

- Kimhi, S. & Doron, H. (2013). Conscripted without order: wives of former combat veterans with PTSD speak. *Psychology*, 4(3), 189-195. doi:[10.4236/psych.2013.43029](https://doi.org/10.4236/psych.2013.43029)
- Klaric, M., Franciskovic, T., Obrdalj, E.C., Petric, D., Britvic, D. & Zovko, N. (2012). Psychiatric and health impact of primary and secondary traumatization in wives of veterans with posttraumatic stress disorder. *Psychiatria Danubina*, 24(3), 280-286.
- Kübler-Ross, E. & Kessler, D. (2014). *On Grief and Grieving: Finding the Meaning of Grief Through the Five Stages of Loss*. New York: Scribner.
- Lambert, J.E., Engh, E., Hasbun, A. & Holzer, J. (2012). Impact of posttraumatic stress disorder on the relationship quality and psychological distress of intimate partners: A meta-analytic review. *Journal of Family Psychology*, 26(5), 729-737. <http://dx.doi.org/10.1037/a0029341>
- Lang, A.J., Laffaye, C., Satz, L.E., Dresselhaus, T.R. & Stein, M.B. (2003). Sensitivity and specificity of the PTSD Checklist in detecting PTSD in female veterans in primary care. *Journal of Traumatic Stress*, 16 (3), 257-264. doi:10.1023/A:1023796007788
- Lapierre, C.B., Schwegler, A.F. & LaBauve, B.J. (2007). Posttraumatic stress and depression symptoms in soldiers returning from combat operations in Iraq and Afghanistan *Journal of Traumatic Stress*, 20(6), 933–943. doi:10.1002/jts.20278
- Larkin, M., Eatough, V. & Osborn, M. (2011). Interpretative phenomenological analysis and embodied, active, situated cognition. *Theory Psychology*, 21, 318-337. doi:10.1177/0959354310377544
- Larkin, M., Watts, S. & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3(2), 102-120. doi:10.1191/1478088706qp062oa

- LeardMann , C.A., Smith, T.C., Smith, B., Wells, T.S., & Ryan, A.K. (2009). Baseline self-reported functional health and vulnerability to post-traumatic stress disorder after combat deployment: prospective US military cohort study. *BMJ*, 338(b1273), Retrieved from: <http://www.bmj.com/content/338/bmj.b1273>
- Lemaire, Ch.M. & Graham, D.P. (2011). Factors associated with suicidal ideation in OEF/OIF veterans. *Journal of Affective Disorders*, 130(1-2), 231-236. <http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1180&context=publichealthresources>
- Lemma, A. (2003). *Introduction to the Practice of Psychoanalytic Psychotherapy*. Chichester: John Wiley & Sons Ltd.
- Lev-Wiesel, R. & Amir, M. (2001). Secondary traumatic stress, psychological distress, sharing of traumatic reminiscences, and marital quality among spouses of Holocaust child survivors. *Journal of Marital and family Therapy*, 27(4), 433-444. doi:10.1111/j.1752-0606.2001.tb00338.x
- Ludlam, M. & Nyberg, V. (Eds.). (2007). *Couple attachments. Theoretical and clinical studies*. London: Karnac Books.
- Lum, H. D., Lo, D., Hooker, S. & Bekelman, D.B. (2014). Caregiving in heart failure: relationship quality is associated with caregiver benefit finding and caregiver burden. *Heart & Lung*, 43(4), 306-310. doi:10.1016/j.hrtlng.2014.05.002
- Lynch, S.H. & Lobo, M.L. (2012). Compassion fatigue in family caregivers: a Wilsonian concept analysis. *Journal of Advanced Nursing*, 68(9), 2125-2134. doi:10.1111/j.1365-2648.2012.05985.x



- Lyons, E. & Coyle, A. (2007). *Analysing qualitative data in psychology*. London: Sage Publication.
- Lyons, M.A. (2001). Living with post-traumatic stress disorder: the wives'/female partners' perspective. *Journal of Advanced Nursing*, 34(1), 69-77. doi:10.1046/j.1365-2648.2001.3411732.x
- MacKay, L. (2012). Trauma and Bowen family systems theory: working with adults who were abused as children. *The Australian and New Zealand Journal of Family Therapy*, 33(3), 232-242. doi: <http://dx.doi.org/10.1017/aft.201228>
- MacManus, D., Dean, K., Bakir, M. Al., Hull, L., Fahy, T. Wessely, S. & Fear, N.T (2012). Violent behaviour in UK military personnel returning home after deployment. *Psychological Medicine* (42), 1663-1673. <http://dx.doi.org/10.1017/S0033291711002327>
- Matsakis, A. (2004). Trauma and its impact on families. In D.R. Catherall, *Handbook of stress, trauma, and the family* (pp.15-33). New York, Hove: Brunner-Routledge.
- McDonald, S.D. & Calhoun, P.S. (2010). The diagnostic accuracy of the PTSD Checklist: a critical review. *Clinical Psychology Review*, 30(8), 976-987. doi: 10.1016/j.cpr.2010.06.012.
- Melvin K., Gross D., Hayat M.J., Mowinski Jennings, B. & Campbell, J.C. (2012). Couple functioning and post-traumatic stress symptoms in US army couples: The role of resilience. *Research in Nursing & Health*, 35(2), 164-177. doi:10.1002/nur.21459
- Middelberg, C. V. (2001). Projective identification in common couple dances. *Journal of Marital and Family Therapy*, 27(3), 341-352. doi:10.1111/j.1752-0606.2001.tb00329.x

- Miller, R.B., Anderson, S. & Kaulana Keals, D., (2004). Is Bowen theory valid? A review of basic research; is Bowen theory valid? A review of basic research. *Journal of Marital and Family Therapy*, 30(4), 453–466. doi:10.1111/j.1752-0606.2004.tb01255.x
- Ministry of Defence (2011). UK Armed Forces mental health: *Annual Summary 2010*  
Retrieved from:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/280706/2010.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/280706/2010.pdf)
- Ministry of Defence (2013). *UK Armed Forces mental health: Annual Summary & Trends Over Time, 2007/08 - 2012/13* Retrieved from:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/280707/2012-13.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/280707/2012-13.pdf)
- Ministry of Defence (2014). *A letter to Defence Statistics (Health) Ministry of Defence*  
Retrieved from:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/295710/foi\\_veterans\\_ptsd\\_1392723878.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295710/foi_veterans_ptsd_1392723878.pdf)
- Monson, C. M., Taft, C.T. & Fredman, S.J. (2009). Military – related PTSD and intimate relationships: from description to theory-driven research and intervention development. *Clinical Psychology Review*, 29, 707-714. doi:10.1016/j.cpr.2009.09.002
- Moore, B.A. (Ed.) (2012). *Handbook of counseling military couples*. New York, Hove: Routledge.

- Morrow, S. L. (2007). Qualitative research in Counselling Psychology: conceptual foundations. *The Counselling Psychologist*, 25, 209-236. doi: 10.1177/0011000006286990
- Muller, R.T., Kraftcheck, E.R. & McLevin, L.A. (2004). Adult attachment and trauma. In D.R. Catherall, *Handbook of stress, trauma, and the family* (pp.139-161). New York, Hove: Brunner-Routledge.
- Mulligan , K., Jones, N., Woodhead, Ch., Davies, M., Wessely, S., Greenberg, N. (2010). Mental health of UK military personnel while on deployment in Iraq. *The British Journal of Psychiatry*, 197, 405-410. doi:10.1192/bjp.bp.110.077263
- Murray, M. (2008). Narrative psychology. In J.A. Smith (Ed.) *Qualitative psychology. A practical guide to research methods* (2<sup>nd</sup> ed., pp.111-133), London, California, New Delhi, Singapore: Sage Publications. Ltd.
- Nelson, B.S. (1998). *Systemic effects of trauma: a quantitative study of individual and relational post-traumatic stress*. Ph.D. Thesis, Texas Technical University. Retrieved from:  
<https://repositories.tdl.org/ttuir/bitstream/handle/2346/14226/31295013268536.pdf?sequence=1>
- Nelson Goff, B.S, Reisbig, A.M., Bole, A., Scheer, T., Hayes, E., Archuleta, K.L., Henry, S.B., Hoheisel, C.B., Nye, B., Osby, J., Sanders-Hahs, E., Schwerdtfeger, K.L., Smith, D.B. (2006). The effects of trauma on intimate relationships: a qualitative study with clinical couples. *American Journal of Orthopsychiatry*, 76(4), 451-460. Retrieved from: <http://dx.doi.org/10.1037/0002-9432.76.4.451>

- Nelson Goff, B.S., Crow, J.R., Reisbig, A.M.J & Hamilton, S. (2007). The impact of individual trauma symptoms of deployed soldiers on relationship satisfaction. *Journal of Family Psychology*, 21(3), 344-353. Retrieved from: <http://dx.doi.org/10.1037/0893-3200.21.3.344>
- Nelson Goff, B.S. & Smith, D.S. (2005). Systemic traumatic stress: the couple adaptation to traumatic stress model. *Journal of Marital and Family Therapy*, 31(2), 145-157. doi:10.1111/j.1752-0606.2005.tb01552.x
- Nicholls, W., Hulbert-Williams, N. & Bramwell, R. (2014). The role of relationship attachment in psychological adjustment to cancer in patients and caregivers: a systematic review of the literature. *Psychooncology*, 23(10).1083-95. doi: 10.1002/pon.3664.
- Nyberg, V. (2007). An exploration of the unconscious couple fit between the “detached” and the “adherent” narcissist: one couple’s shared fear of madness. In M. Ludlam & V. Nyberg (Eds.), *Couple attachments. Theoretical and clinical studies* (pp. 145-157). London: Karnac Books.
- O’Dougherty Wright, M. & Crawford, E, & Sebastian, K. (2007). Positive resolution of childhood sexual abuse experiences: the role of coping, benefit-finding and meaning-making. *Journal of Family Violence*, 22(7), 597-608. Retrieved from: <http://link.springer.com/article/10.1007/s10896-007-9111-1#page-1>
- Orsillo, S.M. (2001) Measures for Acute Stress Disorder and Posttraumatic Stress Disorder, In M.M. Antony, S.M. Orsillo, L. Roemer (Eds.), *Practitioner’s Guide to Empirically Based Measures of Anxiety* (pp. 255-307). New York: Kluwer Academic/Plenum Publishers.

- Ozbay, F., Johnson, D.C., Dimoulas, E., Morgan C.A., Charney, D. & Southwick, S. (2007). Social support and resilience to stress: from neurobiology to clinical practice. *Psychiatry*, 4(5), 35-40. Retrieved from: <https://www.researchgate.net/publication/4609598>
- Palmer, I.P. (2012). UK extended Medical Assessment Programme for ex-service personnel: the first 150 individuals seen. *The Psychiatry online*, 36, 267-270. doi: 10.1192/pb.bp.110.033266
- Pinder, R.J., Greenberg, N., Boyko, E.J., Gackstetter, G.D., Hooper, T.I., Murphy, D., Ryan, M. A.K., Smith, B., Smith, T.C., Wells, T.S. & Wessely, S. (2011). Profile of two cohorts: UK and US prospective studies of military health. *International Journal of Epidemiology*, 41(5), 1272-1282. doi: 10.1093/ije/dyr096.
- Phelps, A., Lloyd, D., Creamer, M., & Forbes, D. (2009). Caring for carers in the aftermath of trauma. *Journal of Aggression, Maltreatment & Trauma*, 18(3), 313-330. doi: 10.1080/10926770902835899
- Ray, S.L. & Vanstone, M. (2009). The impact of PTSD on veterans' family relationships: An interpretative phenomenological inquiry. *International Journal of Nursing Studies*, 46(6), 838-847. doi: 10.1016/j.ijnurstu.2009.01.002
- Renshaw, K.D., Allen, E.S., Carter, S.P., Markman, H.J. & Stanley, S.M. (2014). Partners' attributions for service members' symptoms of combat-related posttraumatic stress disorder. *Behavior Therapy*, 45(2), 187-198. doi: 10.1016/j.beth.2013.10.005.
- Renshaw, K.D. & Caska, C.M. (2012). Relationship distress in partners of combat veterans: the role of partners' perceptions of posttraumatic stress symptoms. *Behavior Therapy*, 43(2), 416-426. doi: 10.1016/j.beth.2011.09.002

- Renshaw, K. D., Allen, E. S., Rhoades, G. K., Blais, R. K., Markman, H. J. & Stanley, S. M. (2011). Distress in spouses of service members with symptoms of combat-related PTSD: secondary traumatic stress or general psychological distress. *Journal of Family Psychology, 25*(4), 461-469 doi: 10.1037/a0023994.
- Renshaw, K.D., Rodrigues, C.S. & Jones, D.H. (2008). Psychological symptoms and marital satisfaction in spouses of Operation Iraqi Freedom veterans: relationships with spouses' perceptions of veterans' experiences and symptoms. *Journal of Family Psychology, 22*(4), 586-594. doi: 10.1037/0893-3200.22.3.586.
- Renshaw, K.D., Rodebaugh, T.L., & Rodrigues, C.S. (2010). Psychological and marital distress in spouses of Vietnam veterans: Importance of spouses' perceptions. *Journal of Anxiety Disorders, 24*(7), 743–750. doi: 10.1016/j.janxdis.2010.05.007
- Ress, J., O'Boyle, C. & MacDonagh, R. (2001). Quality of life: impact of chronic illness on the partner. *Journal of the Royal Society of Medicine, 94*(11), 563-566. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1282240/>
- Riggs, D.S., Byrne, Ch.A., Weathers, F.W. & Litz, B.T. (1998).The quality of the intimate relationships of male Vietnam veterans: Problems associated with posttraumatic stress disorder. *Journal of Traumatic Stress, 11*(1), 87-101. doi:10.1023/A:1024409200155
- Rizq, R. & Target, M. (2010). 'If that's what I need, it could be what someone else needs.' exploring the role of attachment and reflective function in counselling psychologists' accounts of how they use personal therapy in clinical practice: a mixed method study. *British Journal of Guidance & Counselling, 38*(4), 459-481. doi:10.1080/03069885.2010.503699

- Robertson, I. & Cooper, C.L. (2013). Resilience. *Stress and Health*, 29(3), 175-176.  
doi:10.1002/smi.2512
- Rowe, M., Murphy, D., Wessely, S. & Fear, N.T. (2013). Exploring the Impact of Deployment to Iraq on Relationships. *Military Behavioral Health*, 1(1), 13-21.  
doi:10.1080/21635781.2012.721060
- Rozanov, V. & Carli, C. (2012). Suicide among war veterans. *International Journal of Environmental Research and Public Health*, 9 (7), 2504–2519.  
doi:10.3390/ijerph9072505
- Ruszczynski, S. (Ed.). (1993). *Psychotherapy with couples*. London: Karnac Books.
- Scharff, J.S.& Scharff, D.E. (2008). Object relations couple therapy. In A.S. Gurman (Ed), *Clinical Handbook of Couple Therapy* (4<sup>th</sup> Ed., pp. 167-196). New York; London: The Guilford Press.
- Schlenger, W.E., Kulka, R.A., Fairbank, J.A., Hough, R.L, Jordan,B.K., Marmar, Ch.R. & Weiss, D.S.(1992). The prevalence of post-traumatic stress disorder in the Vietnam generation: a multimethod, multisource assessment of psychiatric disorder, *Journal of Traumatic Stress*, 5(3), 333-363. doi:10.1007/BF00977233
- Schnurr, P.P., Lunney, C.A., Sengupta, A. & Waelde, L.C. (2003). A descriptive analysis of PTSD chronicity in Vietnam veterans. *Journal of Traumatic Stress*, 16(6), 545-553.  
doi:10.1023/B:JOTS.0000004077.22408.cf
- Schnurr, P.P., Lunney, C.A., Bovin, M.J. & Marx, B.P., (2009). Posttraumatic stress disorder and quality of life: extension of findings to veterans of the wars in Iraq and Afghanistan. *Clinical Psychology Review*, 29, 727-735. doi: 10.1016/j.cpr.2009.08.006

- Schroder, T. (1991). Approaches to couple therapy. In D. Hopper & W. Dryden (Eds), *Couple therapy: a handbook* (pp.59- 90). Buckingham; Bristol: Open University Press.
- Schumm, W.R., Barnes,H.L., Bollman, S.R., Jurich.A.P. & Bugaighis, M.A. (1986). Self-disclosure and marital satisfaction revisited. *Family Relations*, 35(2), 241-247. doi:10.2307/583631
- Scott, S. & Babcock, J.C. (2010). Attachment as moderator between intimate partner violence and PTSD symptoms. *Journal of Family Violence*, 25(1), 1-9. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662251/>
- Shah, A.J., Wadoo, O. & Latoo, J. (2010). Psychological distress in carers of people with mental disorders. *British Journal of Medical Practitioners*, 3(3), 18 - 24. Retrieved from: <http://bjmp.org/files/2010-3-3/bjmp-2010-3-3-a327.pdf>
- Sherman, M.D., Sautter, F., Jackson, M.H., Lyons J.A. & Han, X. (2006). Domestic violence in veterans with posttraumatic stress disorder who seek couples therapy. *Journal of Marital and Family Therapy*, 32(4), 479-490. doi:10.1111/j.1752-0606.2006.tb01622.x
- Smith, J.A. (Ed.) (2008). *Qualitative psychology. A practical guide to research methods* (2<sup>nd</sup> ed.). London, California, New Delhi, Singapore: Sage Publications Ltd.
- Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis. theory, method and research*. London, California, New Delhi, Singapore: Sage Publications. Ltd



- Snyder, D.K. & Balderrama-Durbin, C. (2012). Integrative approaches to couple therapy: Implications for clinical practice and research. *Behavior therapy*, 43(1), 13-24. doi: 10.1016/j.beth.2011.03.004.
- Southwick, S. M., Bonanno, G.A., Masten, A.S., Panter-Brick, C. & Yehuda, R. (2014). Resilience definitions, theory and challenges: interdisciplinary perspectives. *European Journal of Psychotraumatology*, 5. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4185134/>
- Sternberg, R.J. (1997). Construct validation of a triangular love scale. *European Journal of Social Psychology*, 27, 313-335. Retrieved from: <http://vivanautics.com/pdf/Sternberg1997.pdf>
- Stroebe, M. & Schut, H. (1999). The dual process model of coping with bereavement: rationale and description. *Death studies*, 23(3), 197-222, doi:10.1080/074811899201046
- Stroebe, M. & Schut, H. (2010). The dual process model of coping with bereavement: a decade on. *Omega*, 61(4), 273-289. Retrieved from: <https://www.baywood.com/comppdf/0030-2228.pdf>
- Sugarman, L. (2001). *Life-span development. Frameworks, accounts and strategies*. 2<sup>nd</sup> ed. East Sussex: Psychology Press.
- Sundin, J., Herrell, R.K., Hoge, Ch.W., Fear, N.T., Adler, A.B., Greenberg, N., Riviere, L.A., Thomas, J.L., Wessely, S. & Bliese P.D. (2014). Mental health outcome in US and UK military personnel returning from Iraq. *The British Journal of Psychiatry*, 204(3), 200-207. doi: 10.1192/bjp.bp.113.129569

- Taft, C.T., Watkins, L.E., Stafford, J., Street, A.E., Monson, C.M. (2011). Posttraumatic stress disorder and intimate relationship problems: a meta-analysis. *Journal of Consulting and Clinical Psychology, 79*(1), 22-33. doi: 10.1037/a0022196.
- Tews-Kozlowski, R. & King, D. (2012). Cultural differences. In: B.A. Moore (Ed.), *Handbook of counseling military couples* (pp.321-347). New York, Hove: Routledge,
- Thomas, J.L., Wilk, J.E., Riviere, L.A., McGurk, D., Castro, C.A. & Hoge, Ch.W. (2010). Prevalence of mental health problems and functional impairment among active component and National Guards soldiers 3 and 12 months following combat in Iraq. *Archives of General Psychiatry, 67*(6), 614-623. doi: 10.1001/archgenpsychiatry.
- Transforming the British Army, (2013) Retrieved from: [http://www.army.mod.uk/documents/general/Army2020\\_Report\\_v2.pdf](http://www.army.mod.uk/documents/general/Army2020_Report_v2.pdf)
- Trippany, R., White Kress, V.E. & Wilcoxon, S.A. (2004). Preventing vicarious trauma: what counselors should know when working with trauma survivors. *Journal of Counseling & Development, 81*(1), 31–37. doi:10.1002/j.1556-6678.2004.tb00283.x
- Utzon-Frank, N., Breinegaard, N., Bertelsen, M., Borritz, M., Eller, N.H., Nordentoft, M., Olesen, K., Rod, N.H., Rugulies, R. & Bonde, J.P. (2014). Occurrence of delayed-onset post-traumatic stress disorder: a systemic review and meta-analysis of prospective studies. *Scandinavian Journal of Work, Environmental and Health, 40*(3), 215-229. doi: 10.5271/sjweh.3420
- Valent, P. (1995). Survival strategies: a framework for understanding secondary traumatic stress and coping in helpers. In Figley, Ch.R. (Eds.), *Compassion fatigue. Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 21-51). New York & London: Brunner-Routledge.

- Walker, E.A., Newman E., Dobie, D.J., Ciechanowski, P., Katon, W. (2002). Validation of the PTSD checklist in an HMO sample of women. *General Hospital Psychiatry*, 24(6), 375-80. [http://dx.doi.org/10.1016/S0163-8343\(02\)00203-7](http://dx.doi.org/10.1016/S0163-8343(02)00203-7)
- Weathers F.W., Litz, B.T., Keane T.M., Palmieri, P.A., Marx, B.P., & Schnurr P.P. (2013). *PTSD Checklist for DSM-5 (PCL-5)*. Retrieved from <http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>
- Westerink, J. & Giarratano, L. (1999). The impact of posttraumatic stress disorder on partners and children of Australian Vietnam veterans. *Australian and New Zealand Journal of Psychiatry*, 33(6), 841-847. doi:10.1046/j.1440-1614.1999.00638.x
- Whiffen, W.E. & Oliver, L.E. (2004). The relationship between traumatic stress and marital intimacy. In D.R. Catherall, *Handbook of stress, trauma, and the family* (pp.139-161). New York, Hove: Brunner-Routledge.
- Willig, C. (2001). *Introducing qualitative research in psychology. Adventures in theory and method*. Buckingham, Philadelphia: Open University Press.
- Willig, C. (2008). Discourse analysis. In J.A. Smith, *Qualitative psychology. A practical guide to research methods*. (2<sup>nd</sup> ed., pp. 160-186). London, California, New Delhi, Singapore. Sage Publications. Ltd.
- World Health Organization. (1990). Major depressive disorder. *International statistical classification of diseases and related health problems* (10th ed.). Retrieved from <http://apps.who.int/classifications/icd10/browse/2010/en#/F32>
- Yardley, L. (2008). Demonstrating validity in qualitative psychology In J.A. Smith, *Qualitative psychology. A practical guide to research methods*. (2<sup>nd</sup> ed., pp. 235-252). London, California, New Delhi, Singapore: Sage Publications. Ltd.

- Yeh, Ch, J. & Inman, A.G. (2007). Qualitative data analysis and interpretation in Counselling Psychology: strategies for best practices. *The Counselling Psychologist*, 35, 369-403.  
doi: 10.1177/0011000006292596
- Yehuda, R., Schmeidler, J., Giller, E.L., Siever, L.J. & Binder-Brynes, K. (1998). Relationship between posttraumatic stress disorder characteristics of Holocaust survivors and their adult offspring. *America Journal of Psychiatry*, 155(6), 841-843.
- Zarrabi, H., Njafi., K., Shirazi, M., Farahi, H., Nazifi, F. & Tadrissi., M. (2008). The impact of posttraumatic stress disorder on partner of Iranian veterans. *Acta Medica Iranica*, 46(2), 120-124.
- Zayfert, C. & DeViva, J.C. (2011). When someone you love suffers from posttraumatic stress. What to expect and what you can do. The Guilford Press, New York:, London.

## Appendices

### Appendix 1 The PCL-C Checklist

#### PTSD Checklist-Civilian Form (PCL-C)

*Instructions to patient: "Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then fill in the circle of the response to indicate how much you have been bothered by that problem **IN THE PAST MONTH.**" Please fill in **ONE** option only for each question."*

	<b>Response</b>	<b>Not at all (1)</b>	<b>A little bit (2)</b>	<b>Moder- ately (3)</b>	<b>Quite a bit (4)</b>	<b>Extrem- ely (5)</b>
<b>1.</b>	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?					
<b>2.</b>	Repeated, disturbing <i>dreams</i> of a stressful experience from the past?					
<b>3.</b>	Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening again</i> (as if you were reliving it)?					
<b>4.</b>	Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful experience from the past?					

5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful experience from the past?					
6.	Avoid <i>thinking about</i> or <i>talking about</i> a stressful experience from the past or avoid <i>having feelings</i> related to it?					
7.	Avoid <i>activities</i> or <i>situations</i> because <i>they remind you</i> of a stressful experience from the past?					
8.	Trouble <i>remembering important parts</i> of a stressful experience from the past?					
9.	Loss of <i>interest in things that you used to enjoy</i> ?					
10	Feeling <i>distant</i> or <i>cut off</i> from other people?					
11	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					

<b>12</b>	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?					
<b>13</b>	Trouble <i>falling</i> or <i>staying asleep</i> ?					
<b>14</b>	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?					
<b>15</b>	Having <i>difficulty concentrating</i> ?					
<b>16</b>	Being " <i>super alert</i> " or watchful on guard?					
<b>17</b>	Feeling <i>jumpy</i> or easily startled?					

Total score:

**Appendix 2** Letters requesting, or granting, consent from any collaborating institutions



Dear Sir/Madam,

My name is Joanna Cobley and I am 3<sup>rd</sup> year Practitioner Doctorate Counselling Psychology student at the University of Wolverhampton. My research supervisors are supervisor is Dr Wendy Nicholls. I am currently working on my research project, which will explore the experiences of partners of military personnel (both serving and veterans). My particular interest in this study is around the issue of ST, resulting from living with military personnel who can potentially suffer from posttraumatic stress disorder (PTSD).

I am currently seeking participants for my study, and hoping you would be willing to kindly provide me with some help in this aspect. I am looking into recruiting 10-30 female or male partners of military personnel who would be interested in participating. I would be grateful if you would distribute leaflets to potential participants and/or display a poster in the building of your organisation, inviting potential participants to a participation in the study. I would also be grateful if you could suggest to me any other appropriate ways of recruiting participants through your organisation. Also, it would be helpful if I could arrange a meeting on your premises with potential participants, explaining the study to them in more detail.

I am looking forward to hearing from you and to discussing further details of the study. You are more than welcome to get in touch with me on [tel.no. redacted] or via e-mail at [email address redacted] Also, should you wish to speak to my supervisor Dr Wendy Nicholls . [email address & tel. no. redacted]

Yours faithfully, Joanna Cobley



**Appendix 3** *Formal information sheet about the study.*



GENERAL INFORMATION SHEET

Study Title: Exploring the Impact of Secondary Traumatization on Partners of Military Personnel.

The study will be conducted by Joanna Cobley - a student of Practitioner Doctorate Counselling Psychology at the University of Wolverhampton- and will be a part of her Doctorate Portfolio. Joanna's supervisor is Dr Wendy Nicholls [email address redacted] [tel. no. redacted]

The research aims to investigate the experiences of male and female partners of military personnel with posttraumatic stress disorder (PTSD) (both in active and non-active service) who appear to be experiencing secondary traumatization. The reasoning behind choosing this particular target population is that this should lead to a more robust consolidation of people with secondary traumatization. This is because military personnel are being exposed to traumatic experiences significantly more frequently than an average sample of population, due to them taking part in military actions.

The study consists of two stages: a short self-report checklist and one hour long semi-structured interview. Participants who decide to take part in the study will be asked to sign a consent form. They will be given a choice of taking part in the study over the phone, Skype or in the preferred method of face-to-face meetings. Participants will be offered an opportunity to talk about your experiences and any impacts of taking part in the study after each stage of the study.

Participants will first be invited to fill in the PTSD Checklist for Civilians (PCL-C), containing seventeen 'tick-box' questions which relate to the way people experience general stressful life experiences. Completing the checklist will take about 5-10 minutes. Responses to the checklist will be used to assign a score to each participant. The researcher will apply a cut-off score, which will be used to determine progression to the second stage of the study. The second stage will involve an informal semi-structured interview, which will be conducted only with those participants who reach or exceed the cut-off score. This interview, which will take about an hour, will be recorded and then transcribed by the researcher.

All the data collected in the study will be treated as confidential and will be kept in a safe, locked place and destroyed when not needed any more for the purposes of this study. All personal details collected in the study will be used only for the purpose of contacting in relation to the study. All personal data obtained in the interview will be anonymised in order to minimise any risk of potential harm or unintended consequences for participants. Participants will be able to contact the researcher or her supervisor should they have any questions or concerns, and will be free to withdraw their participation from the study at any stage.

The researcher will endeavour to ensure that the well-being of participants is taken into account at every stage of the study. At the end of each stage, participants will receive information about potential support they could access should they feel that the study brought up something sensitive for them. If a participant becomes distressed at any stage, their feelings will be normalized and the researcher will allow them to decide whether they would like to continue the study.

All participants may receive a summary of the results and the full study report on completion, which is expected to be in the summer 2014. Participants wishing to receive this, or to discuss

any other aspect of their participation, may contact the researcher on [tel. no. redacted] or send an email at [e-mail address redacted].

**Appendix 4** *The Poster and Leaflet.*



***Has your partner had PTSD (post-traumatic stress disorder) due to military service?***

***Are you a wife, husband or partner of a military personnel who has experienced PTSD***

***AND***

***would you like to share your experiences?***

If so, you are invited **to take part in the study**, which intends to:

- Highlight the individual experiences of living with military partners who have experienced PTSD.
- Explore the impacts of PTSD on the partners of military personnel, resulting in possible secondary traumatisation.

The study consists of a short ***self-report checklist*** and, in some cases, an hour long ***informal follow-up interview*** with the researcher. All of the data obtained in the research will be treated confidentially.

The researcher is Joanna Cobley, a Practitioner Doctorate Counselling Psychology student at the University of Wolverhampton. Her supervisor is: Dr Wendy Nicholls [[e-mail address redacted](#)]

**If you are interested in taking part in the study**

**please contact Joanna Cobley on [tel. no. redacted] or [[e-mail address redacted](#)]**

**Appendix 5** *Invitation to the study*



**Has your partner suffered from Post Traumatic Stress Disorder (PTSD) due to military service?**

If you are a wife, husband or partner of a Service person who has experienced PTSD, you are kindly invited to take part in the study into the impact of being a partner of serving military personnel or veterans with PTSD.

The study intends to highlight the individual experiences of living with a Service partner who has experienced PTSD and to explore the impact of this. It will be conducted by Joanna Copley, a Practitioner Doctorate Counselling Psychology student at the University of Wolverhampton.

The study consists of a short self-report checklist. In some cases, there may be an informal follow up interview with the researcher (about an hour). All the data obtained will be treated confidentially and any personal data will be anonymised.

If you are interested in taking part in the study or would like some more information, please  
contact

Joanna Copley on [tel. no. redacted] or [**e-mail address redacted**]

Her supervisor is: Dr Wendy Nicholls (**e-mail address redacted**)

**Appendix 6** *Information sheet for participants about the study*



**PARTICIPANT INFORMATION SHEET**

Study Title:

Exploring the Impact of Secondary Traumatization on Partners of Military Personnel

You have been invited to participate in a study focusing on the experiences of living with partners who are in active and non-active military service and have experienced post-traumatic stress disorder (PTSD) as a result of their military service. It is believed that the impact of their traumatic experiences might have a negative impact on partners and spouses and result, in some cases, in a condition called 'secondary traumatization'. This condition refers to experiencing trauma symptoms through indirect exposure to traumatic experiences.

The study aims to establish and describe the direct and indirect effects of partners' military experiences on participants with special attention placed on the possibility of them experiencing secondary traumatization. It will explore how participants make sense of their experiences and how they deal with them. The study will be conducted by Joanna Cobley - a student of Practitioner Doctorate Counselling Psychology at the University of Wolverhampton. Joanna's supervisors is Dr Wendy Nicholls [e-mail address redacted] [tel. no. redacted]

The study has two stages: a short self-report checklist and an informal interview. Should you agree to take part in the study- you will be asked to sign a consent form. You would be given a choice of taking part in the study over the phone, Skype or in the preferred method of face-

to-face meetings. After each stage of the study you will be given an opportunity to talk about your experiences and any impacts of taking part in the study.

You will first be invited to answer the self-report checklist, containing seventeen 'tick-box' questions which relate to the ways that people experience general stressful life experiences. For each question, you will need to tick one box marking your response. Filling in the questionnaire will take about 5-10 minutes. Afterwards, those who attain a certain score on the self-report checklist will be invited to a one hour long informal interview. The interview does not use a set list of questions but rather topics for discussion. The researcher remains sensitive to the natural flow of conversation. The aim is to allow the participant room to explore issues which they feel are particularly relevant to the study, rather than being constrained by a more rigid format. The interview will take be recorded digitally and then written up by the researcher.

All the data from the study will be treated as confidential and will be kept in a safe, locked place and destroyed when not needed any more for the purposes of this study. All personal details such as participants' contact details or names will be used only for the purpose of contacting participants in relation to the study. All personal data obtained in the interview will be anonymised. You will be able to contact the researcher or her supervisors should you have any questions or concerns, and will be free to withdraw from the study at any stage.

All participants may receive a summary of the results and the full study report on completion, which is expected to be in the summer 2014. Participants wishing to receive this, or to discuss any other aspect of their participation, may contact the researcher on [tel. no. redacted] or send an email at [e-mail address redacted].

**Appendix 7** Demographic questionnaire



DEMOGRAPHIC QUESTIONNAIRE

Please fill in a short demographic questionnaire:

**Name:** .....

**Sex:** Please circle: M/F

**Age:**

Please circle: 18- 25    25-35    35-45    45-55    55-65    65-75

**Occupational role:** .....



**Appendix 8** Consent Form



CONSENT TO PARTICIPATE IN THE STUDY

Study Title: Exploring the Impact of Secondary Traumatization on Partners of Military Personnel

I have been asked to participate in a research study which will investigate the experiences of wives', husbands' and partners' of military personnel. The study consists of two parts: completing a short self-report checklist and taking part in 1 hour long semi-structured interview. I give my free consent to participate in the interview by signing this form.

Please tick each box to show you understand each aspect of the study:

- I have been informed about the research and why it is taking place.
- I understand that my participation in this research is voluntary.
- I understand that I can withdraw from the research at any time.
- I understand that my data will be treated as confidential.
- I understand that my data will be kept in a safe, locked place.
- I understand that I can receive the results from the study.
- I understand that researcher's supervisor and her external examiners will have access to my data.

- I understand that the interview will be recorded and typed up.
- I understand that my participation will be anonymous and that my contact details will be used by the researcher only to contact me in relation to the study.
- I understand that quotes from the interview might be used, in an anonymised form, in the research publication.
- I understand that I will have the opportunity to talk about my experiences of taking part in the study.
- I understand that I will be asked to complete a short questionnaire and, possibly, to be invited to an informal interview.

.....

Printed Name of participant	Date	Signature
-----------------------------	------	-----------

The researcher: Joanna Cobley [tel. no. redacted]; e-mail address: [e-mail address redacted]

Researcher's supervisor: Dr Wendy Nicholls [tel. no. redacted]; e-mail address: [e-mail address redacted]

**Appendix 9** *The covering letter*



Dear ....

Thank you for taking interest in the study which intends to Exploring the Impact of Secondary Traumatism on Partners of Military Personnel.

As agreed in our initial conversation, please find attached Participant Information Sheet which will give you more information about the study, Demographic Questionnaire and a consent form to participate in the study.

I hope that you decide to participate in the study as you will have an invalid input into highlighting the individual experiences of living with a Service partner who has experienced PTSD and to explore the impact of this. If so, I would like to ask you to send signed consent form back to me via post in a pre-addressed and pre-paid envelope which I had sent to you. You can also send signed consent form electronically, with your electronic signature. I would also appreciate if you send back completed Demographic Questionnaire. As soon as I receive your consent form – I will get in touch with you to arrange the best time and date for you to take part in the study.

If you have any queries, you are more than welcome to get in touch with me on [tel. no. redacted] or via e-mail at [redacted]. Should you wish to speak to my supervisors: Dr Wendy Nicholls [email & tel. no. redacted]).

Hope to hear from you soon,

Yours sincerely, Joanna Cobley

**Appendix 10A** *A debriefing sheet to be used in individual debriefings with participants who completed the PCL-C Checklist.*



Thank you for completing self-report checklist.

The study that you have taken part in intended to establish how and to what extent you have been affected by your partners' experiences in the military, especially as a result of them suffering from certain psychological conditions such as posttraumatic stress disorder (PTSD). It is believed that caring for partners who experience PTSD and sharing their experiences might result in experiencing so-called secondary traumatisation. The likely presence of this condition was investigated in the self-report.

If you have any queries, you are more than welcome to get in touch with me on [redacted] or via e-mail at [redacted] You can also contact my supervisor Dr Wendy Nicholls [email address & tel. no. redacted]

If you have found yourself being affected by taking part in completing the PCL-C Checklist in any negative way or you would like to further explore the issues that you talked about, please bear in mind that there is support available for you. You could get in touch with [APPROPRIATE FOR PARTICIPANTS' COUNTRY OF RESIDENCE CONTACT TO BE INSERTED HERE]. If in the UK: *The Samaritans on 08457909090, with your GP or with charities such as: Help for Heroes - telephone number: 01980846459 (<http://www.helpforheroes.org.uk>), SSAFA support group on the telephone number: 02074038783 (<http://www.ssafasupportgroups.org.uk>) or Combat Stress on the telephone number: 08001381619.]*

Also, please let me know, either by phoning me or sending an e-mail, if you wish to obtain a summary of the results, or the full project report, when it is completed. This is predicted to be in the summer 2014.

**Appendix 10B** *A debriefing sheet to be used in individual debriefings after semi-structured interviews.*



The study that you have taken part in intended to establish how and to what extent you have been affected by your partners' experiences in the military, especially as a result of them suffering from certain psychological conditions such as post-traumatic stress disorder (PTSD). Special attention was paid to trying to establish what effect your partners' traumatic experiences have had on you and your well-being. It is believed that caring for partners who experience PTSD and sharing their experiences might result in experiencing so-called secondary traumatisation. The potential presence of that phenomenon was investigated both in the self-report and in the interview.

If you have any queries, you are more than welcome to get in touch with me on [redacted] or via e-mail at [redacted]. Also, you can speak to my supervisor Dr Wendy Nicholls [email address & tel. no. redacted]

Once again, I would like to remind you that if you have found yourself being affected by the interview in any negative way or you would like to further explore the issues that you talked about, please bear in mind that there is support available for you. You could get in touch with [APPROPRIATE FOR PARTICIPANTS' COUNTRY OF RESIDENCE CONTACTS TO BE INSERTED HERE. IF IN TE UK: *The Samaritans on 08457909090, with your GP or with charities such as: Help for Heroes - telephone number: 01980846459 (<http://www.helpforheroes.org.uk> ), SSAFA support group on the telephone number:*

02074038783 (<http://www.ssafasupportgroups.org.uk>) or *Combat Stress* on the telephone number: 08001381619.]

Also, please let me know, either by phoning me or sending an e-mail, if you wish to obtain a summary of the results, or the full project report, when it is completed. This is predicted to be in the summer 2014.

**Appendix 11** *An interview schedule*

**Interview Schedule**

- a) **Tell me about your partner’s military service** (prompts: where was your partner stationed; his role in military).
- b) **What are your thoughts about partner’s/husband’s/wife’s work in the military?** (prompts: opinions of their work; effect of their work on the family).
- c) **How would you describe your relationship with your partner?** (prompts: equality or patriarchy; static or evolving quality of relationship).
- d) **Does your partner “bring” work issues home?** (prompts: conversations; results of the conversations; signs of their partners being affected by their work).
- e) **What impact has your partner’s work had on you?** (prompts: practical, organisational, emotional impact; direct and indirect; the biggest difficulty).
- f) **How do you cope with the impact of your partner’s work on you?** (prompts: coping mechanisms- what are they and how they work; areas of not coping).
- g) **What kind of effects, that you are aware of, does your partner’s work have on him/her?** (prompts: physical and psychological effects; medical or psychological diagnosis).
- h) **What do you think is the impact of your partner’s condition/well-being, resulting from his/her work-related experiences, on you?** (prompts: feelings and thoughts about diagnosis; reactions to their partners behaviour).
- i) **How did it feel being interviewed today?** (prompts: any insights?; any surprises?).

---

Interview Location

\_\_\_\_\_

Interview Start Time

\_\_\_\_\_

Interview Finish Time



**Appendix 12** Participant information sheet given to participants before the semi-structured interview (if the first part of the research (PCL-C Checklist) was done on the phone).



**PARTICIPANT INFORMATION SHEET**

Study Title:

Exploring the Impact of Secondary Traumatization on Partners of Military Personnel

You have been invited to participate in the second part of the study focusing on the experiences of living with partners who are in active and non-active military service and have experienced post-traumatic stress disorder (PTSD) as a result of their military service. The study aims to establish and describe the direct and indirect effects of partners' military experiences on participants and how they understand and deal with them. Special attention is placed on the possibility of participants experiencing secondary traumatization, which results from being indirectly exposed to traumatic experience of their partners.

The first part of the study you have taken part in was to fill in the self-report Checklist. The score that you attained suggested some that you may have been affected by some traumatic experiences in your lives. As a result, you have been invited to a semi-structures interview to talk, in more detail, about your experiences and how you deal with them. The interview will take about an hour and it will be an informal discussion, guided by the researcher. After the interview, you will be able to talk about how the interview has been for you.

All the data from the study will be treated as confidential and will be kept in a safe, locked place and destroyed when not needed any more for the purposes of this study. All personal

details collected in the first stage of the study has been used only for the purpose of contacting you in relation to the study. All personal data obtained in the interview will be anonymised.

You will be able to contact the researcher Joanna Copley on [tel. no. redacted] or send an email at [email redacted] or her supervisor is and Dr Wendy Nicholls [email address & tel. no. redacted] should you have any questions or concerns, and will be free to withdraw your participation from the study at any stage.

Should you agree to take part in this stage of the study, you will be asked to sign a consent form before this stage of the study.

**Appendix 13** *Participants' log*

PARTICIPANT LOG

Name	Gender	Age	Occupation	Number of children if any	Contact details: a)telephone number b)e-mail address c)postal address

