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MILITARY SPOUSES' EXPERIENCES OF LIVING ALONGSIDE THEIR UK SERVING PARTNERS DURING A MENTAL HEALTH ISSUE

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Military spouses’ experiences of living alongside their UK serving partners during a mental health issue.

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Abstract

One in eight UK Armed Forces personnel will seek healthcare from military services for a mental health related issue (Ministry of Defence, 2020). Furthermore, the presence of a mental health illness is the second most leading cause of divorce within the serving military population.

A review of the literature found only one qualitative study exploring the experiences of UK military spouses ‘providing informal care to wounded, injured or sick (WIS) personnel’ (Thandi et al, 2016; p 1). However, it is noted that not all the WIS personnel in this study had a mental health issue. There appears to be no current qualitative research which specifically explores military spouses’ experiences of living alongside a UK serving partner with a mental health issue. This study therefore aimed to explore the military spouse’s lived experience with a view to understanding and informing future developments of supportive strategies specific to military spouses.

The study used a qualitative, biographical methodology, collecting data through life stories. Two face-to-face semi-structured interviews took place with nine military spouse who were recruited through military spouse networks and snowballing. The military spouses were all married to UK Army personnel across a range of ranks.

Lieblich et al.’s (1998) work offers framework for analytical pluralism, which encompasses both the completeness of the story and the generation of themes or categories. Following Lieblich et al.’s (1998) two-stage life story analysis approach, the participants’ stories are presented in the stages ‘*in the beginning’*, *changing times’* and *‘this is me’*. Using Lieblich et al.’s (1998) categorical – content approach, six overarching categories were identified.

The study is the first of its kind within the UK. Several original contributions to knowledge arose. The study emphasizes how the mood status of the military spouse is affected by their serving partners mental health status. The study also illustrates the military spouse experience in the period before diagnosis. The study highlights the challenges faced, relationship protective factors and the effects on the marital relationship. It emphasizes the need for support and inclusion strategies of the military spouse from treatment services, in order to keep the military spouse well, provide vital support and aid the recovery journey of their serving partner. The study illustrates the lack of both formal and informal support because of the perceived stigma and fear of being judged. Finally, the convergence of findings facilitated the generation of a conceptual U-curve illustration depicting the trajectory of the military spouse’s journey of living alongside their serving partner during a mental health issue.

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Acknowledgements

'At times our own light goes out and is rekindled by a spark from another person.

Each of us has cause to think with deep gratitude of those who have lighted the flame within us.' A. Schweitzer

This PhD journey has been one of the most amazing learning experiences of my academic career. It has been emotional and has challenged me in ways I could have not imagined but has opened my eyes to new possibilities and ways of thinking. I feel privileged for having had this opportunity and forever grateful to those who have nurtured, supported and believed in me.

Firstly, I would like to thank my principal supervisor Amanda Clarke for your guidance, patience, and constant encouragement. Thank you for challenging me and asking those *'hard'* questions. Most of all, thank you for sharing my journey.

Gemma Menzfeld-Wilson who took a role within my PhD supervision team. Thank you for all your support, guidance and feedback. Thank you to Anne McNall who always believed in me from the very beginnings of my academic career. And thank you to all my colleagues in the Nursing, Health and Midwifery department, who have supported me in different ways.

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To my children, Abbie, Jack and Eve,,,,,the three of you are my inspiration, to be the best that I can be. And to my grandson, Isaac….. you are my little shining light, thank you for the joy you have brought.

Finally, I feel privileged to have had the opportunity to undertake this research which allowed me to listen to the participants' experiences and shine a light on those who sometimes feel invisible yet play a crucial role in supporting the health and wellbeing of serving personnel. I feel honoured that they welcomed me into their lives, to share their difficulties, losses, and loneliness but also the '*good'* days they shared and the love they felt for their serving partner during a mental health issue. And that they entrusted me to be the one to share their stories with a

wider audience to inform policy and practice so that in the future, others experiencing similar situations might not feel so alone. For that I am forever grateful, thank you.

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this commentary has been approved. Approval has been sought and granted through the Researcher's submission to Northumbria University's Ethics Online System on 26th January 2018.

I declare that the Word Count of this Thesis is 93,526 words.

Name: Emma Senior

Date: 1st October 2022

Glossary of terms

Bluey	Word used by the armed forces to describe ‘letters home’
Camp	Military base or establishment
Commissioned	Rank of an Officer
Deployment	Name given to serving personnel’s time away from family when engaged in operational duties
Non-commissioned	Other ranks of serving military personnel
Regiment	Military unit
Tour	Shortened term from ‘tour of military duty’ away from family
Tri-services	Pertains to all three military services: Army, Navy & Air force
Unit	Shortened term for ‘military unit’ – a part or group which part of military service – they have specific combat or support role within a larger military organisation

List of abbreviations

CMD	Common Mental Disorder
CQC	Care Quality Commission
DH	Department of Health
DMS	Defence Medical Services
FOB	Forward operating base
IED	Improvised explosive device
MOD	Ministry of Defence
NHS	National Health Services
NICE	National Institute for Health & Care Excellence
NMC	Nursing & Midwifery Council
OIF	Operation Iraqi Freedom
OEF	Operation Enduring Freedom
PND	Post Natal Depression
PTSD	Post Traumatic Stress Disorder
R&R	Rest and recuperation
SFA	Service Family Accommodation
UK	United Kingdom
USA	United States of America
WIS	Wounded, injured and sick

1 Chapter 1. Introduction to the thesis

1.1 Introduction to chapter: was I the only one?

To begin this thesis, I draw upon the arguments posed by Chandler (1990) and Collins (1992) that often, there is little known about why a researcher participates in research and indeed, what background experiences or personal viewpoints helped form their research question. Below is my truncated story which after writing, left me thinking: am I the only one? I could have made it longer and more detailed but felt only the necessary points were needed; the detail and depth of the stories in this research belong to the participants and are its central focus.

Following the return from a tour in Afghanistan, my husband experienced severe adjustment disorder, a mental health disorder for which I was not fully prepared. As a nurse, health visitor and SHA, I felt that I had acquired a degree of knowledge and skills in caring for someone requiring support, guidance, and reassurance in adjusting to new/different situations. I also understood how family support and family inclusion can positively impact on recovery journey and/or maintenance of a mental health issue; however, at times, my inability '*to reach'* my husband left me with a sense of uselessness. As his symptoms and behaviour worsened, after much persuasion, treatment was sought, and the erratic behaviour slowly stopped. Life returned to a different '*normal*,' meaning there remained an air of caution and carefulness from both of us. During that period, I never felt more alone and more invisible. There was self-blame and self-loathing, leading to a huge lack of self-confidence.

In a move to rationalise and come to terms with my experience, I started a journey of discovery to try to understand my experience; was it unique or had others experienced something similar? And so the seed was sown……..

This thesis reports the research undertaken to explore the experiences of intimate partners when they have found themselves living alongside their serving partner during a mental health issue. The intention of this chapter is to set the scene and provide context for the research aims and question. A definition of mental health issues is identified for the purpose of this study. Global and UK mental health prevalence is briefly considered prior to discussing mental health prevalence in the military. Current UK policy pertaining to mental health is briefly explored. Finally, the research question is introduced together with a precis of the subsequent chapters.

1.2 Study background

Mental health prevalence

Establishing a specific term for mental health conditions is problematic as many variations exist and are used synonymously in literature and policy guidelines, such as mental disorder/illness, mental health disorders, conditions, problems, or issues (World Health Organisation (WHO), 2022; Mind, 2022; National Health Service (NHS), 2022). The WHO (2022) uses mental disorder to refer to a plethora of diagnosable mental health conditions as described by the International Classification of Diseases 11th Revision (ICD-11, 2022). Diagnosable mental health conditions are characterised by how they clinically cause a significant effect on an individual's emotional regulation, cognition and/or behaviour. These include anxiety disorders, mood disorders, personality disorders, eating disorders, post-traumatic stress disorders and psychotic disorders (WHO, 2022). Despite the synonymous use of terms, conversely, the term mental health problem is often used for those who, whilst experiencing acute stress reactions and changes to mood, thinking and behaviour, may not meet the mental disorder diagnosable criteria. Primarily, these present because of life stressors and can be situational, they are often less severe and resolve with time; however, persistent or increased severity in the mental health problem may develop into a diagnosable mental disorder (ICD-11, 2022, Everymind, 2022). Due to the complexities arising from the plethora of terms used in the literature, I sought advice from colleagues specialising in mental health in order to establish the most appropriate term to use here. Consequently, the umbrella term '*mental health issue*' is used throughout the thesis to describe mental health disorders of the serving partner.

Globally, mental health issues are one of the main causes of ill health, accounting for 13% of disease burden and by 2030, this figure is predicted to rise to 15% (Vos et al., 2015; Murray et al., 2012). In 2019, the WHO purported that 970 million people worldwide, equating to one in eight people were living with a mental disorder (WHO, 2022). It is also estimated that a quarter of the population, at some point in their lives, will experience a mental health illness (WHO, 2017). Across the world, major depression is considered to be the second leading cause of disability (Whiteford et al., 2013); with depression, anxiety and drug use reported as the primary drivers of disability in people aged between 20-29 years (Lozano et al., 2012).

In the UK, it is approximated that in any given year, one in four people experience a mental health issue (NHS England, 2022). Mind (2017) suggest that within the UK, 300 people out of every 1000 experience some form of mental health issue annually and of those, three quarters seek help from their General Practitioner (GP). 17.7% of adults meet the diagnostic criteria of at least one mental health issue (McManus et al., 2009; National Institute for Health and Care Excellence (NICE, 2009). Within England, it is estimated that 16.67% adults experience a common mental disorder (CMD) and that 1: 3 adults with CMDs receive treatment specific to their mental health problem (McManus 2016). It is approximated that by 2026, there will be a 17% increase, taking the figure to 1.45 million UK citizens diagnosed with depression alone (NICE, 2022). With the increased prevalence of mental health issues, comes a rise in financial cost, not only for health and social services (estimated at £13 billion, NICE, 2022), but also across the wider economy through the impact placed on workplace productivity. 72% of the cost is attributed to lost work productivity of either the person with a mental health problem or of the unpaid informal carers. Currently, the combined cost to UK society is estimated to be £117.9 billion (McDaid & Park, 2022).

From a military perspective, military studies report a wide range of mental health issues with active serving personnel (Moradi et al, 2021; Whybrow et al., 2015; Fear et al., 2010). The last twenty years has seen considerable interest arising from both a political and a public standpoint around the mental health of serving personnel because of military combat and humanitarian operations, for example, Iraq, Afghanistan, Sierra Leone and Libya, (Centre for Social Justice, 2011; Samele, 2013). In 2019/20, there were 5,544 recorded new mental health cases within the UK armed forces; on assessment, neurotic disorders which includes adjustment disorder and PTSD were most prevalent with over a third of the diagnoses; followed by mood disorders (depression and anxiety) accounting for 32% of diagnoses (Ministry of Defence, (MOD) 2020). Fear et al. (2010) reported that 4% had probable post-traumatic stress disorder (PTSD) and 19.7% reported other CMDs. As well as the stressors arising from military operations, other psychosocial stressors can be precursors to a mental health issue, with Finnegan et al.'s (2014) study reporting that stressors such as relationship/family problems and occupational issues were the leading causes of depression within the armed forces, irrespective of age, gender or rank. More recent figures suggest that the global prevalence of depression across the military is between 23-26 % (Moradi et al., 2021), considerably higher than the general population, where the estimated figure is 13-15% (Vos et al., 2015). Across the Tri-services, the prevalence of depression was greater, with personnel from the Army (33.4 per 1000) in comparison to the Royal Air Force (RAF, 29.9 per 1000), Royal Navy (23.8 per 1000) and the Royal Marines (14.4 per 1000) (MOD, 2014). More recently the percentage of those seeking mental health care across the UK tri-services has levelled, with the Royal Air Force having the highest proportion (14.3%), Navy (12.9%), Army (12.4%) and Royal Marines with the lowest proportion (8.3%), (MOD, 2020). The MOD (2020) reports that the rates of personnel assessed in ‘other ranks’ was greater than that of officers (1:34 and 1:66 respectively). Despite the higher prevalence of mental health issues in the military (Goodwin et al., 2015), Iversen et al.’s UK study (2011) reported that the overall treatment rate in their sample was 13%, which was much lower than that of the general UK population at the time (26%). It is suggested that up to 60% of serving personnel with a mental health illness will not seek treatment (Hoge et al., 2004; Sharp et al., 2015; Hom et al., 2017). In summary, the prevalence of depression in active serving military populations is greater than that of a non-military population.

Mental health support

For the UK general population, formal support and treatment for a mental health issue is provided by the National Health Service (NHS) and further supported by the third sector, such as MIND, Mental Health Foundation. Provision is supported by a raft of policy and guidance (Mental Health Act, 2007; GOV.UK, 2017, 2019, 2022; NICE, 2009,2011, 2022). In contrast, mental healthcare provision for UK serving personnel is provided in-house by Defence Medical Services (DMS) in the Department of Community Mental Health (DCMH). These services, however, are aligned to and delivered following the same policies and guidance as the National Health Service (NHS), along with additional in-house policies such as the Defence People Mental Health and Wellbeing Strategy 2017-2022 (GOV.UK, 2017). Similarly, to the NHS, DMS are regulated by the Care Quality Commission (CQC) who monitor the services to ensure that patients/clients and their families have access to *safe, effective compassionate and high-quality care* (CQC, 2017). Current UK policy and guidance which informs both the NHS, and DMS mental health care provision promotes the inclusion of family or carers within the care for the person with the mental health issue. The inclusion of the main carer in the treatment of a client with a mental health issue can aid a recovery journey (Waller et al., 2019) and provide vital support in managing the condition for both the client and their family (Foster and Isobel, 2018; Maybery and Reupert, 2018). There is no one accepted definition of a recovery journey which is widely recognised as being unique to everyone (rethink.org, 2022). Within the context of this thesis, the term recovery describes the move towards mental well-being; holding a sense of purpose and hope in life whether the individual is living without symptoms or living with their mental health issue. Such provision is documented in NICE guidelines (2011, 2022) which explicitly reference carers' involvement and the requirement that they be provided written and verbal information regarding diagnosis and treatment, positive outcomes and recovery, support for themselves, the role of the teams and services involved and how to get help in a crisis. NICE (2022) highlight that one of the outcomes of implementing these guidelines is to reduce family breakdown, especially pertinent in the context of the military, since it has been reported that the presence of a mental health illness is the second most leading cause of divorce within the serving military population (Monson et al., 2009).

Despite the raft of policy supporting mental health service provision and family/carer involvement across the NHS and DMS, there continues to be a lack of healthcare management models, resulting from underfunding and austerity measures (Rafferty et al., 2017; Cummins, 2018). This has led to similar finding across the general (Von Kardorff et al., 2016) and military (Stevelink et al., 2019) populations, in that care provision for those with a mental health issue, predominantly falls to family members.

Within the general population, the impact on quality of life for family caregivers can be wide and far reaching (Dadson et al., 2018, Phillips et al. 2022). Zeighami and Ahmadi (2021) report that despite policy promoting inclusion, very often spouses and other family members are omitted from the treatment process which induces greater stress. Other studies also suggest a correlation between care burden and negative health effects such as increased stress, physical exhaustion, anxiety and depression for the caregiver (Lawn and McMahon, 2014; Mulud and McCarthy, 2017; Phillips et al., 2022).

From a military context, this is further compounded, because even without the existence of a mental health issue, it is recognised that there are significant effects on the military family environment, especially during times of deployment with military families experiencing a higher prevalence of psychological disorders (Moradi et al., 2021). Indeed, to have the additional factor of the serving partner with a mental health issue within the family environment, the impact on quality of life of the military spouse may be further impeded. This was recognised in a review by the Centre for Social Justice (2011) surrounding the level of support received by service families whilst living alongside wounded, injured or sick (WIS) personnel. The review identified that UK provision was minimal and predominantly delivered through third sector organisations or Service Family Federations such as the Army Families Federation, Naval Families Federation, and the RAF Families Federation. A report by Engward et al., (2018) surrounding limb loss also recommended that policy should consider family needs with a cultural shift in the direction of family-centred care and rehabilitation.

Whilst there is a plethora of literature surrounding military partners/families and deployment (Lowe et al., 2012; Long, 2021), a preliminary scope of the literature showed there is minimal literature surrounding the mental health of serving personnel and the military partner's experience. Both Crotty, (1998) and Polit and Beck (2014) suggest multiple realities exist, so I chose to take a much more open stance which allowed the participants to construct and share their realities as they experienced them. Underpinning this study, was the desire to gather unique, in-depth rich data; to do this Holloway and Jefferson (2000) propose the use of broad, undefined exploratory questions. So as not to make assumptions and predetermine the direction of the study I chose not to use labels such as carer, care or support in my aim and simply focused on the experience of *living alongside*.

1.3 The aim of the research

Following this preliminary scope of the literature, my initial aim was to explore the experiences of intimate partners living alongside their UK serving partner during a mental health issue.

The criteria were that:

- participants were the intimate partner (wife, girlfriend, husband, boyfriend, partner) of serving personnel of any rank across the tri-services, Army, Navy or RAF
- their serving partner had at some point during their serving career experienced a mental health issue; namely, common mental health disorders (depression, anxiety), adjustment disorder, or post-traumatic stress disorder.

To differentiate between the two partners, I use the umbrella term '*military spouse*' or '*participant'* throughout the thesis to describe the intimate partner (wife, girlfriend, husband, boyfriend, partner) and I use '*serving partner*' to describe the participant's partner who has served with the UK Armed Forces.

1.4 Organisation of thesis

Chapter 1 provides a frame for this thesis and highlights why it is important that the experiences of military spouses living alongside their serving partner during a mental health issue is explored. The study's definition of mental health issues is provided. The mental health issues and impact on the families is located in the context of prevalence, service provision and the UK Armed Forces. Lastly, the initial research aim is identified.

Chapter 2 presents the systematic narrative literature review, including the process undertaken and the findings – presented using narrative synthesis. Founded on this identified the gap in the empirical literature and subsequently, the research aim, and objectives of the study were refined. The literature review was ongoing throughout the duration of this study in order to include new publications.

Chapter 3 introduces the conceptual thinking that informed the development of this study. The chapter illustrates the conceptual thinking based on the literature review findings, my experiential understandings, and my research aim and objectives. My conceptual thinking moves beyond individual concepts and provides a theoretical base and a clear lens through which the methodology and data analysis were determined. Three theoretical concepts were identified as a lens through which to explore military spouses' experiences of living alongside their serving partners with a mental health issue: importance of stories, military culture and feminism.

Chapter 4 details the research methodology and methods chosen for this study. First, biographical approaches are critiqued, concluding in a rationale for choosing life stories as the method of data collection. The use of life stories is aligned to the conceptual framework and informs data analysis. This chapter also details an explanation of the research process undertaken. It includes the sampling strategy, recruitment process, a critical reflection on my role as researcher/military wife within the research, ethical considerations, data collection and analysis in which Lieblich et al.'s (1998) framework was used.

Chapter 5 and the following chapter describe my findings. Chapter 5 presents a summary of the participant and relationship characteristics, followed by the participants' individual stories, using Lieblich et al.'s (1998) life story analysis. This was important to give seldom heard (military spouses) a voice, to explore their experiences in context and holistically. Their stories are presented in three stages: in the beginning, changing times and this is me.

Chapter 6, following Lieblich at al. (1998), brings the stories together; identifying categories and subcategories across participants' experiences, so that similarities and differences can be explored. Using an interpretative framework, six categories are presented and discussed. Through the convergence of my conceptual thinking and the two sets of findings, a predominant trajectory of the participant journey 'the U-curve journey' is discussed.

Chapter 7 is the discussion chapter. It reconsiders the conceptual framework that underpinned the choice of methodology and analysis. It draws together the study's main findings, to explore and better understand participants' experiences within the wider context of previous research and theory. It presents the study's original contributions to knowledge, its overarching strengths and limitations and implications for future research, policy and practice. The chapter culminates by presenting the thesis' main conclusions.

2 Chapter 2: Literature review

2.1 Introduction to chapter

This chapter presents a systematic narrative literature review of the relevant literature and research in context of this study. From preliminary exploration of the topic, there was limited literature available. A systematic narrative literature review was performed in acknowledgement of the limited evidence around the research topic to ensure a wide range of literature and research designs were sought (Snilstveit et al., 2012). The literature review was ongoing throughout the duration of this research to include new publications and deeper exploration of categories identified during data analysis. On completion of the literature review, a gap in the existing body of knowledge specifically regarding military spouses of UK serving personnel was identified. Finally, the aim and objectives of the research are presented.

2.2 Systematic narrative literature review

Chapter 1 discussed the background and the context of this thesis. The aim of this research was to explore the experiences of military spouses living alongside their UK serving partner during a mental health issue. Literature reviews are an essential component in the research process as they offer an insight into how knowledge is created (Wu et al., 2012). Literature reviews also demonstrate the process of thinking and re-thinking and the researcher's personal learning journey (Williamson & Whittaker, 2019).

A systematic narrative literature review was executed to enable the inclusion of a wide range of literature and research designs (Snilstveit et al., 2012) and in acknowledgment of the limited evidence around the research topic found from my initial scope of the literature. Qualitative evidence can answer different but often complementary questions to quantitative evidence (Snilstveit et al., 2012). A systematic narrative literature review assumes a narrative synthesis approach concerned with generating new insights and recommendations textually, going beyond the statistical manipulation of findings (Popay et al., 2006; Snilstveit et al., 2012). Narrative synthesis brings together findings from all the included studies to capture conclusions. Using a deductive approach, these conclusions form thematic groups based on the body of evidence as a whole (Popay et al., 2006; Snilstveit et al., 2012). Criticisms of narrative synthesis include the lack of formal guidance, clarity regarding the method (Mays et al., 2005) and the lack of transparency

(Dixon-Woods et al., 2006). However, Popay et al. (2006) provide guidance to help overcome these obstacles, proposing four main elements within the narrative synthesis process:

- Developing a theory of how the intervention works, why and for whom
- Developing preliminary synthesis of finding of included studies
- Exploring relationships in the data
- Assessing the robustness of the synthesis

(Popay et al., 2006, p11).

As a guide to each of the four elements, activities are identified. The process, however, is iterative; encouraging the researcher to move freely within each element, rather than approaching them linearly in a sequential manner (Popay et al., 2006).

This review specifically focuses on the spouse experience, and only aims to include studies whereby the spouse is identified in the aim or outcome. From the research aim, search terms were developed using the framework PICO and a systematic search strategy was utilised to ensure that the searches are transparent to reduce bias in the retrieval of relevant literature and selection of the inclusion papers (Snilstveit et al, 2012). Initial searches yielded limited literature specific to the military spouses', however a reference and citation search was executed on all relevant papers to increase the number of papers, broadening the literature review. The literature review was carried out in two phases: as the review of the literature was executed early in this study, a further search using the initial search terms was performed to ensure up-to-date studies were included.

Throughout the papers there are several terms used when referring to those who have participated in the studies. For the literature review, the nouns '*spouse*' or '*participant*' are used when referring to the intimate partner, wife/husband of the veteran/serving person and the term '*serving/veteran partner'* used when referring to the serving person or veteran.

Search term development

As Snilstveit et al. (2012) suggest, drawing on a theoretical framework is useful for identifying relevant terms for a particular topic or issue; from the research aim, search terms were developed using the framework PICO (Table 1). Whilst the aim of the research specifically highlighted experience, I included support and care within the outcome to broaden the searches.

Table 1: PICO

Search term development	
P - Patient or population	(Wife; husband; spouse; partner; intimate) AND (armed forces; Army; Navy; Airforce; military; soldier/s – truncated to soldi*, tri-service; sailor/s; airman/airmen; marine)
I - Intervention	Mental; psychological; psychology; psychologist (truncated to psychologi*)
C – Comparison (if applicable)	Not applicable
O - Outcome	Support; experience, care; caring; carer (truncated to car*)

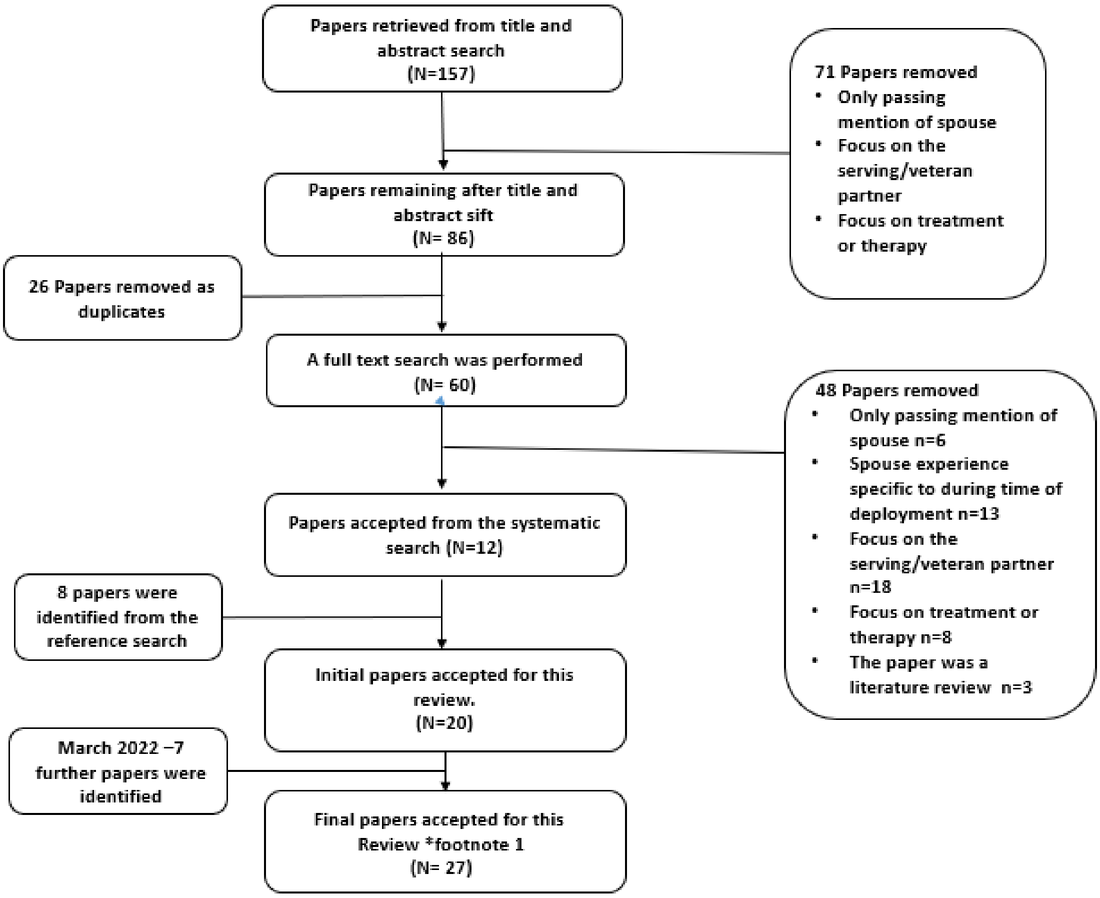
Suitable databases were identified and used for the searches: CINHAL, ASSIA, Proquest Psychology, Proquest Nursing & Allied Health source, Proquest Dissertations & Theses, ETHOS, PsychArticles, Hospital collection, Medline, Science Direct Freedom Collection. All relevant search terms were utilised, and initial searches yielded limited literature specific to spouses. The publication date was broadened to include any papers from any publication date; however, consideration was only given to those papers written in the English language. See table 2 for inclusion criteria.

Table 2: Inclusion criteria

Year of publication	2008-2018 *(to reflect the contemporary evidence base – broadened due to limited numbers initially retrieved)*
Source	Northumbria Library ASSIA (Applied Social Sciences Index & Abstracts) CINAHL (Cumulative Index to Nursing & Allied Health Literature) ETHOS (E-Theses online Service) Hospital Collection Medline Proquest Nursing & Allied Health source Proquest Psychology Science Direct Freedom Collection PsycArticles
Search Field	Title, Abstract, Keyword
Language	English only
Search terms - Military	(Wife OR husband OR spouse OR partner) AND (armed forces OR military OR soldi*) AND (Mental OR psychologi*) AND (Support OR experience OR car*)

The initial search took place in 2016 with another search completed in March 2022. A further reference and citation search was executed on all relevant papers to increase the number of papers, also broadening the literature review. A total of 157 articles were retrieved from the initial searches with 86 being deemed of some relevance following a title and abstract sift (Figure1).

Figure 1: Paper selection



Data extraction and study quality appraisal

26 papers were removed as duplicates and following a full-text search, a further 48 papers were excluded as: only passing mention of spouse (n=6), the spouse experience was specific to during the time of deployment (n=3), the focus of the study was the serving/veteran partner (n=18), the focus was directed at a treatment or therapy (n=8) and the remaining were literature reviews (n=3). Reference and citation searches were executed on all relevant papers, resulting in eight further papers eligible for inclusion. A total of 20 papers initially included in this review. To bring the narrative literature review up to date, a further search was carried out in March 2022[1] yielding seven more papers for review, bringing the total number to 27.

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[1] To bring the systematic narrative literature review up to date an additional search was carried out in March 2022, a further seven papers were retrieved and have been added to the findings

From the 27 papers included in the review, the study aim, sample size, method and tools, plus the location of study were extracted (Table 3). Steps 2–4 of the Economic Social Research Council's (ESRC) guidance on the conduct of narrative synthesis was employed (Popay et al., 2006). This guidance proposes four stages; however, the process is iterative, encouraging the researcher to move freely within each stage and not approach them linearly in a sequential manner (Popay et al., 2006). Stage one was excluded as this was not the aim of this review. In stage 2 and 3, the initial synthesis of the findings in the included papers was completed, followed by an exploration of the relationship between the findings. Stage 4 required an assessment of the quality of the synthesis.

When reviewing the selected research literature, a process of critical appraisal was executed to determine if the literature was trustworthy, relevant and appropriate to this study (Popay et al., 2006; Jesson et al., 2011). Identifying the strengths and weaknesses in each paper, allows the researcher the ability to give more weight to the stronger papers (Aveyard, 2014). The final selection of 27 papers up for scrutiny consisted of eleven quantitative, fourteen qualitative and two mixed methods studies; however, it is the qualitative element within these studies that was of interest for the review. All the quantitative studies selected with the inclusion of the mixed methods studies, employed questionnaires/surveys as the method of data collection. An adapted quality assessment tool for quantitative papers was applied to each study (Thomas et al., 2004). The studies were assessed against seven sections which were ranked as either strong, moderate or weak. An overall ranking was then applied (appendix 1). Only one study was deemed strong, with nine ranked as moderate and one study regarded as weak. A strength throughout all the quantitative studies was the use of valid data collection tools. Whilst the tools varied across the studies selected, the tools are recognised and have been used within other studies outside of this review. For the remaining 16 qualitative/mixed methods papers, the criteria developed by Kuper et al., (2008) was used to assess domains such as overall coherence of the study, sampling, data collection, analysis, transferability of results and ethical. Studies were ranked from unclear, acceptable, good or very good. Papers were included if they ranked acceptable or above in four of the six domains (appendix 1). Similar to the quantitative studies, the majority (11 studies) were ranked as good, only two studies were deemed as very good, with the remaining three studies ranked as acceptable.

Table 3: Overview of the 27 studies included in the review

	Author	**Aim of study**	**Sample size**	**Method used**	**Location**
1	Allen, E.S, Rhodes, G.K. Stanley, S.M. & Markman, H.J. (2010)	To examine whether a recent history of deployment and current PTSD symptoms are related to several aspects of marital functioning.	434 married couples	Quantitative – questionnaire of self-reported measures: • Deployment • PTSD Checklist (PCL) • Relationship functioning Which included Kansas Marital Satisfaction Scale (KMS) Confidence Scale Positive Bonding Scale, Parenting Alliance Inventory (PAI) Dedication Scale Satisfaction with Sacrifice Scale Communications Danger Signs Scale	USA
2	Beckman, J.C, Lytle, B.L. & Feldman, M.E. (1996)	To study prospective burden in partners of Vietnam veterans with PTSD: a) to examine changes in caregiver burden that occur over time b) to determine the degree to which caregiver burden relates to their own adjustment c) to evaluate the degree to which changes in caregiver burden relate to changes in adjustment over the follow-up.	58 couples- Vietnam war veterans and partners	Quantitative – mail-out survey, comprising: demographic information, Burden Interview (BI), Symptom Checklist -90- Revised (SCL-90-R) Beck Depression Inventory (BDI) Speilberger State and Trait Anxiety Inventory (STAI)	USA

3	Brown, V. A. (2015)	To gain an in-depth understanding or essence of the transformative experiences of partners of junior and mid-grade enlisted soldiers in the rank of E-1 to E-6 who were wounded in combat operations in support of the War, to learn how these women learn to make new meaning of their life circumstances as a result of profound and dramatic changes in their lives and life experiences as a result of those injuries and to determine how society can better support them.	15 women spouses (5 x face to face interviews and 10 x over telephone interviews)	Qualitative – hermeneutic/interpretive phenomenological methodology. Data collected in two phases: Phase 1 – participant profile questionnaires Phase 2 – individual interviews, utilising an individual interview protocol consisting of statements, definitions and questions to frame interviews.	USA
4	Buchanan, C. Kemppainen, J. Smith, S. MacKain, S. & Wilson, C. (2011)	To identify perspectives of female spouses/intimate partners regarding posttraumatic stress disorder in returning Iraq and Afghanistan combat veterans.	34 x participants	Mixed – Quantitative approach for demographic data Qualitative approach using critical interviews to explore with partners: • How they would know if their military spouse needed treatment for PTSD • What behaviours would indicate to them that their spouse was willing to receive treatment for PTSD • In the event that their spouse needed treatment and resisted it, what would it take on their part to get them into treatment.	USA
5	Campbell, S.B. & Renshaw, K.D. (2013)	To examine the associations among a) service member‘s PTSD symptoms	Time point 1 = 224 service	Quantitative Time point 1 – questionnaire given in person	USA

		b) service members‘ emotional disclosure to partners c) relationship satisfaction in both partners within military couples over two time points.	members and 214 partners Time point 2 = 83 service members and 91 partners	Time point 2- questionnaire emailed to participants Measures used: • PTSD Checklist (PCL) • Likelihood of Disclosure Scale • Relationship Assessment Scale (RAS) To test three seperate hypothesis 1. Association of service members‘ PTSD symptoms at time 1, service person and partner report of disclosure at time 2 and service members and partners relationship satisfaction at time 2 2. Emotional numbing would be the individual cluster most strongly associated with relationship satisfaction for both partners 3. That service members emotional disclosure at time 2 would mediate associations of service members time 1 PTSD symptoms with both partners time 2 relationship satisfaction.	
6	Daniels, J. A. (2013)	To examine the relationship between the level of burden of care and the perception of social support reported by spouses of OIF and OEF reserve veterans who had been diagnosed with PTSD.	61 x participants	Quantitative – survey monkey developed to include: 1. Demographic questionnaire 2. Zarit Brden Interview (ZBI) which used a 5-point Likert Scale to measure burden	USA

				3. Social Support Index (SSI) To test the four seperate hypothesis; namely: 1. The level of burden of care reported by the spouse of OIF and OEF reserve veterans diagnosed with PTSD will be negatively correlated with the level of perceived social support reported. 2. The level of burden of care reported by the spouses of OIF and OEF reserve veterans diagnosed with PTSD will be higher when there are dependant children in the home. 3. The level of perceived social support reported by the spouse of OIF and OEF reserve verterans diagnosed with PTSD will be lower when there are dependant children living in the home. 4. The level of burden of care reported by spouses of OIE and OEF reserve verterans diagnosed with PTSD who have dependant children living in the home will be negatively correlated with the level of perceived social support.	
7	Iniedu, A. O. E. (2010)	To assess the incidence of STS and explore the experiences of a sample of	10 x participants	Mixed methods - Quatitative assessment tools and interviews.	USA

		wives of Iraq and Afghanistan war veterans diagnosed with PTSD.		Quantitative methods used: 1. Basic demographic qusetionnaire 2. Secondary Traumatic Stress Scale (STSS) with a score of 38 or above to be considered diagnostic of STS Qualitative method used: 1. Face-to-face semi-structured interview	
8	Jordan, B.K, Marmar, C.R, Fairbank, J.A, Schlenger, W.E, Kulka, R.A, Hough, R.L. & Weiss, D.S (1992)	To improve on the methodology of previous studies of the effects of PTSD on families by recruiting a community sample rather than a treatment seeking sample to compare levels of problems in the families of Vietnam veterans with or without PTSD.	862 veterans & 376 spouses/ partners	Quantitative – Interview, using questionnaire. Not all measures included the spouse/partner. Indexes given to Spouse/Partner for completion were: • Marital Problem Index • Family Adjustment Index • Level of Life Functioning Index • Family Violence Measures • Index of Subjective Wellbeing • PERI Demoralisation Scale • Social Isolation Index • Alcohol Problems Measure • Drug Problems Measure • Nervour Breakdown Measure • Total Behaviour Problems Score from the Child Behaviour Checklist	USA
9	Lyons, M. A. (1999)	To examine what is like for the wives/female partners to live with a Vietnam veteran who suffers from Post-traumatic stress disorder.	10 x participant	Qualitative – phenomenological study Interviews with open-ended questions were used to ask the partners of veterans:	USA

				• What their early relationship was like • What PTSD symptoms their partner experiences and how they cope with them • What feelings they experience in their relationship with their partner • Why they stay or why they leave the relationship. • How different they are now from the start of the relationship/before their partner experienced symptoms.	
10	Manguno-Mire, G. Sautter, F. Lyons, J. Myers, L. Perry, D. Sherman, M. Glynn, S. & Sullivan, G. (2007)	To examine the psychological distress among co-habiting female partners of combat veterans with posttraumatic stress disorder.	89 co-habiting partners	Quantitative – telephone survey using the Partner Experiences with PTSD survey (PEPS) – a synthesis of three published instruments: • PTSD Checklist (Military) • Burden Inventory • Brief Symptom Inventory and seven study-specific scales developed by a team of content experts in PTSD treatment and family therapy.	USA
11	Mansfield, A.J. Schaper, K.M. Yanagida, A.M. & Rosen, C.S. (2014)	To provide a description of the lived experience of partners of veterans diagnosed with PTSD by examining the written words of their significant other.	252 x participants	Qualitative -a smaller study using the results of a quantitative – postal survey which included an option for written comments; namely: • If there is anything else that you would like to share relating to PTSD	USA

				in veterans and your own experiences, please do so below. The written comments were analysed qualitatively	
12	Renshaw, K.D. & Caska, C.M. (2012)	To determine whether patterns of findings replicated across fairly large samples from two separate combat eras.	Study 1 = 258 couples in which one member had served in the Utah National Guard/ reserves during Operation Enduring freedom and 9 Iraqi freedom Study 2 = 465 couples who participated in the National Vietnam readjustment study	Quantitative – questionnaires Study 1: 1. PTSD checklist (PCL) 2. Adapted PCL for partners 3. Depression Anxiety Stress Scale (DASS) 4. Relationship Assessment Scale (RAS) Study 2: 1. Mississippi Scale for Combat-Related PTSD 2. Marital Problems Index (MPI) 3. Psychological Distress Index (PDI)	USA
13	Riggs, D.S, Byrne, C.A., Weathers, F.W. & Litz, B.T. (1998)	To examine the association of relationship difficulties with clusters of PTSD symptoms	50 couples – Vietnam veterans and their female partners	Quantitative – self-reporting questionnaires which included: 1. Dyadic Adjustment Scale (DAS) 2. Marital Status Inventory (MSI) 3. Relationship Problems Scale (RPS)	USA

				4. Fear of Intimacy Scale (FIS) 5. PTSD Checklist- Military version (PCL-M) All questionnaires used were to test PTSD and relationship distress PTSD and measures of relationship quality Association of relationship quality and PTSD symptom clusters Emotional numbing and effortful avoidance associated with relationship difficulties.	
14	Sautter, F. Lyons, J.A. Manguno-Mire, G, Perry, D. Han, X. Sherman, M. Myers, L. Landis, R & Sullivan, G. (2006)	To use the behavioural model of health service utilization to identify predictors of partner PTSD treatment engagement.	83 x participants	Quantitative – Telephone survey using: 1. Patient PTSD Survey (PPS) 2. Partner Experiences with PTSD Survey (PEP) The PEP scale measured the following: Patient-Partner Involvement Perceived Barriers to Treatment Perceived Benefits of Treatment PTSD Self-efficacy Caregiver Burden Partner PTSD Treatment Engagement.	USA
15	Sherman, M.D. Blevin, D. Kirchner, J Ridner, L & Jackson, T (2008)	To: a) explore the perceived appropriateness and potential benefits to partner participation b) identify perceived risks and barriers to partner participation	10 couples	Qualitative – semi-structured interviews were conduted seperatley with each individual. The interviews focused on the following domains: 1. Knowledge of how families can become involved in the veterans	USA

		c) use these findings to develop strategies to solicit partner involvement in mental health treatment.		mental health care at Oklahoma City VA Medical Centre (VAMC) 2. Perceptions and feelings about the appropriateness of family involvement 3. Benefits that family involvement may have for the veterans, partners and families 4. Concerns about partner participation in the veterans care 5. Logistical issues or barriers to participate in family programming 6. Approaches for inviting partners to participate in family programming (Who? Where? How?).	
16	Temple, J. McInnes Miller, M. Banford Witting, A & Kim, A.B. (2017)	To explore wives' experiences of living with active-duty Marines who are diagnosed with post-traumatic stress disorder.	8 x participant	Qualitative – a phenomenological inquiry utilising semi structured interviews with a central question: What is it like for you to live with an active-duty male marine with PTSD?	USA
17	Verbosky, S.J. & Ryan, & D.A. (1988)	To explore a) what is the effect of Vietnam veterans' PTSD symptoms on women partners b) how do the symptoms of PTSD interrelate with identified women's issues c) is there a relationship between veterans' symptoms and the coping skills exhibited by women partners?	23 x participants	Qualitative – group therapy consisting of structured and non-structured activities. Data was collected from content and process notes from weekly therapy sessions held for significant others. From the sessions the areas that were documented were: 1. Problem identification	USA

				2. Effects of PTSD on the subjects 3. Specific women's issues 4. Available coping skills.	
18	Waddell, E Pulvirenti, M & Lawn, S (2016)	To explore the multidimensional nature of experiences for caring for Australian veterans with PTSD from the perspectives of their intimate partners, with an emphasis on understanding coping.	20 x participants	Qualitative – an interpretive phenomenological approach using in-depth semi-structured, face-to-face interviews.	Australia
19	Woods, J. N. (2010)	To explore the lived experience of a military dependant spouse when an Army soldier returns from Iraq and/or Afghanistan with Posttraumatic stress disorder.	10 x participants	Qualitative – Phenomenological approach using semi-structured interviews.	USA
20	Yambo, T.W. Johnson, M, E. Delaney, K. R. & York, J.A. (2016)	To explore the experiences of military spouses living with veterans with combat-related posttraumatic stress disorder.	14 x participants	Qualitative – Husserlian phenomenology using unstructured interviews.	USA
21	Calhoun, P.S., Beckham, J.C. & Bosworth, H.B. (2002)[1]	To provide further examination of the association between PTSD symptom severity, caregiver burden, and psychological adjustment in partners of patients with PTSD.	71 couples – Vietnam veterans and their partners	Quantitative – survey including demographic data, Zarit Burden interview (22-point self-reporting measure) and Symptom Checklist-90 (SCL-90-R).	USA
22	Thandi, G., Oram, S., Verey, A., Greenberg, N., & Fear, N.T. (2016)[1]	To investigate the relationship experiences of non-military partners caring for WIS UK military personnel.	25 x participants	Qualitative – semi-structured telephone interviews.	UK

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[1] To bring the systematic narrative literature review up to date an additional search was carried out in March 2022, a further seven papers were retrieved and have been added to the findings.

23	Martinez, L.M (2018)[1]	To examine the relationship between the veteran's level of disability and dyadic stress on the military caregiver's overall sense of well-being.	70 x participants	Quantitative – Questionnaires used were: • Demographic questionnaire • World Health Organization Disability Assessment Schedule (WHODAS 2.0) • Couples Satisfaction Index (CSI-16) • Experience in Close Relationships – Short Form (ECR-SF) • Multidimensional Scale of Perceived Social Support (MSPSS) • Zarit Burden Interview (ZBI) • Satisfaction with Life Scale (SWLS) • Patient's Health Questionnaire (PHQ-15).	USA
24	Murphy, D., Palmer, E., Hill. K., Ashwick, R. & Busuttil, W. (2018)[11]	To explore the experiences and needs of female partners of Veterans with mental health difficulties.	8 x participants	Qualitative – Interpretative phenomenology using semi-structured interviews.	UK
25	Waddell, E., Lawn, S., Roberts, L., Henderson. J., Venning, A., Redpath,	To examine the multidimensional nature of experiences of being an intimate partner of a contemporary Veteran with posttraumatic stress disorder (PTSD).	10 x participants	Qualitative - phenomenological approach using face-to-face semi-structured interviews.	Australia

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[1] To bring the systematic narrative literature review up to date an additional search was carried out in March 2022, a further seven papers were retrieved and have been added to the findings.

	P. & Sharp-Godwin, T. (2020)[1]				
26	Brickell, T.A., Cotner, B.A., French, L.M., Carlozzi, N.E., O'Connor, D.R., Nakase-Richardson, R. & Lange, R.T. (2021)[1]	To examine the influence of traumatic brain injury (TBI) severity on the health-related quality of life of caregivers providing care to service members/veterans (SMV) following a TBI.	30 x participants	Qualitative – participants attended one of six focus groups.	USA
27	Johnstone, H. & Cogan, N. (2021)[1]	To explore intimate partners' views of the role they play in supporting Veterans with mental health difficulties, and the personal meanings they associate with this role.	6 x participants	Qualitative - phenomenological approach using face-to-face semi-structured interviews.	UK

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[1] To bring the systematic narrative literature review up to date an additional search was carried out in March 2022, a further seven papers were retrieved and have been added to the findings.

Paper characteristics

Proposed by Snilstveit et al. (2012), the first step in identifying thematic groups is to assess the characteristics of the selected studies. For ease, each study is allocated a number for identification and referencing in this chapter's discussion. Table 4 identifies some of the fundamental characteristics within each of the 27 studies.

The focus differed amongst the studies, with nine studies including both veteran or serving partner as well as the spouse, denoting the spouse element was part of a much larger study [1, 2, 4, 5, 8, 13-15, 21]. In these cases, the spouse findings have been used within this review. Eighteen studies had specific focus on the spouse [3, 6, 7, 9-12, 16-20, 22-27]. Six studies had a specific focus on the spouse experience whilst their partner was still serving [1, 3, 5, 16, 19, 22], the other twenty-one studies focused on the spouse experience cohabiting with the veteran population [2, 4, 6-15, 17, 18, 20, 21, 23-27]. All but six studies [3, 22, 23, 24, 26, 27] paid specific attention to PTSD and PTSD symptoms only. Within fifteen studies, the serving/veteran partner had a clinical PTSD diagnosis [2, 3, 6, 7, 9-11, 14, 15, 17-20, 21, 25]. Seven studies self-reported PTSD with 4 studies [1, 8, 12, 13] using a clinically recognised symptom assessment and classification tool (DSM-III or DSM-IV) to justify participant selection. The remaining five studies, [22, 23, 24, 26, 27] except [26] did not specifically identify the mental health disorder.

Nineteen studies identified specific military conflicts. Nine studies specifically focused on more recent conflicts, Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) in Iraq [1, 4-6, 16, 19, 22, 23, 25] and eight studies related to the Vietnam or Persian Gulf conflicts [2, 8, 9, 13-15, 17, 21]. One study included participants from both Vietnam and OEF/OIF [18]. One study [12] compared and contrasted findings between two separate studies, with study one focusing on OEF/OIF and study two focusing on Vietnam. Eight studies did not make any reference to any specific conflict [3, 7, 10, 11, 20, 24, 26, 27].

In all studies included within this review, the gender of the spouse was majority female. Nine studies acknowledged the duration of the relationship, with six studies identifying an average of up to 18 years [1, 4, 5, 19, 24, 25] and two studies having an average of 26 years plus [11, 18]. Nineteen of the studies did not specify a duration or an average was not calculated [2, 3, 6-10, 12-17, 20, 21, 22, 23, 26, 27].

Across the 27 studies, a range of recruitment methods were executed. Ten studies utilised formal avenues; four used couples-based marriage enrich workshops [1, 5, 11, 17], six used outpatient PTSD clinics [2, 10, 14, 15, 21, 24], and three via random selection from military records [8, 12, 23]. Six studies used advertising [3, 6, 13, 19, 23, 27], two studies used a snowballing method [9, 20] and two studies utilised a combination of both [16, 18]. Three used third-party services specific to veterans and families [4, 25, 26] and one study recruited from a church group [7].

Table 4: Paper characteristics

Article number	Author	War related				Average duration of relationship (years)	Specific to Spouse only	Couple	
		Un-specified	OEF/OIF	OEF/OIF/ Vietnam	Vietnam / Persian				
1	Allen et al. (2010)		X			4.7		X	
2	Beckham et al. (1996)				X	Not stated		X	
3	Brown (2015)	X				Not stated	X		
4	Buchanan et al. (2011)		X			12.8		X	
5	Campbell & Renshaw (2013)		X			11.7		X	
6	Daniels (2013)		X			Not stated	X		
7	Iniedu (2010)	X				Not stated	X		
8	Jordan et al. (1992)				X	Not stated		X	
9	Lyons (1999)				X	Not stated	X		
10	Manguano-Mire et al. (2007)	X				Not stated	X		
11	Mansfield et al. (2014)	X				26.7	X		

12	Renshaw & Caska (2012)			X		Not stated	X		
13	Riggs et al. (1998)				X	Not stated		X	
14	Sautter et al. (2006)				X	Not stated		X	
15	Sherman et al. (2008)				X	Not stated		X	
16	Temple et al. (2017)		X			Not stated	X		
17	Verbosky & Ryan (1988)				X	US	X		
18	Waddell et al (2016)			X		42	X		
19	Woods (2010)		X			9.3	X		
20	Yambo et al. (2016)	X				US	X		
21	Calhoun et al. (2002)				X	Not stated		X	
22	Thandi et al. (2016)		X			Not stated	X		
23	Martinez (2018)		X			Not stated	X		
24	Murphy et al. (2018)	X				18.4	X		
25	Waddell et al. (2020)		X			14.9	X		
26	Brickell et al (2021)	X				Not stated	X		
27	Johnstone & Cogan (2021)	X				Not stated	X		

Twenty-two studies were carried out in the United States of America [1-17, 19-21, 23, 26]. Two studies were carried out in Australia [18, 25] and three studies were completed in the UK [22, 24, 27]. Two studies utilised a mixed method approach [4, 7], fourteen utilised a qualitative method [3, 9, 11, 15-20, 22, 24-27] and eleven utilised a quantitative method [1, 2, 6- 8, 10, 12-14, 21, 23]. A range of data collection methods were utilised. Thirteen studies carried out questionnaires or surveys [1-3, 5-8, 10, 12-14, 21, 23] and two studies offered an opportunity for free text within their questionnaire [4, 11]. Seven studies carried out face-to-face interviews [3, 7, 9, 15, 16, 18, 19, 24, 25, 27], one study used telephone interviews [22], and a further study choose to use a combination of face-to-face and telephone interviews [20]. Only one study opted for observation and documentation [17] and one opted for focus groups [26] as the method of choice.

Whilst there was commonality in the overarching themes being tested within the quantitative studies, that unity was not evident in the selection of tools, inventories and scales used to collect the data. Three different scales were used in more than one study. The PTSD checklist was utilised in three studies [1, 5, 12] with a further two studies using a modified military version [10, 13]. The Burden Inventory was cited in four studies [2, 10, 21, 23] and a further three studies named the Relationship Assessment Scale. [5, 12. 23]. All the qualitative studies used in-depth interviews as the chosen method of data collection [3, 7, 9, 15, 16, 18- 20, 22, 24, 25, 27] with the exclusion of one [17] which used an unobtrusive data collection method (observation of a support group). Most studies opted for semi-structured interviews leading the participants to specific areas of interest. Only one study chose unstructured interviewing, the researchers opened the interview by asking the participant to "*describe an experience that exemplified what it was like to live with a veteran with PTSD*" (Yambo et al. 2016, p545). All the qualitative studies who used interviews as the chosen data collection method performed only one interview with their participants except Brown (2015) who undertook two interviews. Whilst one in-depth interview is recognised as a data collection method in qualitative research, it is also argued that having more than one interview with each participant allows for greater richness and depth to the data (Liamputtong, 2019). All the qualitative studies selected thematic analysis to develop their findings.

Analysis of the retrieved studies was undertaken to identify emerging themes. Five themes were identified; three distinct themes featured in over half of the studies and a further two themes emerged from over 25% of the studies. The five themes are:

- Theme 1: Caregiver burden
- Theme 2: Relationships
- Theme 3: Psychological/psychosocial effects on the spouse
- Theme 4: Mental health service provision
- Theme 5: Spouse’s knowledge and management of PTSD symptoms.

A matrix of the papers and themes identified can be seen in appendix 2.

Theme 1: Caregiver burden.

Prior to exploring this theme, caregiver burden must be defined in the context of this review. Zarit et al. (1986) define it as the extent to which caregivers perceive their emotional or physical health, social life, or financial status to be affected by their caring for an impaired relative. Vitalinao et al. (1991) suggest that the concept of caregiver burden includes both an objective element such as strained relationships, financial constraints, and a subjective element such as the reactions and responses because of the demand placed on the carer; all of which are associated with caring for someone with a long-term physical or mental illness. Juntunen et al. (2018) and Friedman & Buckwalter (2014) posited that the spouse of the cared for individual, are potentially higher risk of experiencing caregiver burden and poorer mental health as opposed to other family, friend or unrelated carers, due to residing together and increased long-term exposure to each other. The last twenty years has seen the notion of caregiver burden applied to the spouses of combat veterans with PTSD (Cuijpers and Stam, 2000; Arzi et al., 2000; Calhoun et al., 2002; Dekel et al., 2005b; Manguno-Mire et al., 2007).

The notion of caregiver burden was cited in seventeen studies [1, 2, 3, 6, 9-11, 14-16, 18, 20-22, 25-27]. Yambo et al. [20] identified two differing types of care burden; first, the psychological burden, discussed in theme 3 and secondly, the burden from the practical and physical actions required from the carer; the assumption of duties and responsibilities whereby *…You step in, you take care of it for them* (p547). Mirrored in Sherman et al.’s [15] study; the need to provide emotional and behavioural support was deemed important by half of their participants (n=5). To provide such support very often required a change in role; this was identified in nine of the studies [3, 9, 11, 15, 16, 18, 20, 22, 25]. Waddell et al.’s [25] study described wide ranging roles, from taking on new household tasks to being the *primary* *decision-makers across many life issues in the family unit* (p43). Within five studies [3, 9, 11, 16, 20], the spouses stated that they felt more like a care provider than a wife; being an advocate for their serving/veteran partners' care. A quote from Temple et al. [16] states *the relationship feels like I'm a nurse v's the spouse* (p171). In some cases, this change of role was taken on voluntarily; however, for some spouses, the change in role felt forced upon them as a result of their serving/veteran partner being unable or unwilling to perform a role within the relationship, [3, 9, 16, 27]. Apparent in four of the studies' findings [3, 11, 15, 18], was the naivety of spouses regarding their appreciation of longevity of the caregiver role; thinking that the role would be temporary, rather than the emerging long-term/permanent reality. Waddell et al.'s [18] study proposed that this disillusionment was met with resignation; all the participants (n=20) identified that their lives centred around the needs of their serving/veteran partners, and they had reached a level of acceptance, believing nothing could be done to change that fact.

One of the ways the long-term impact was identified, was the manifestation of the need to constantly maintain the '*peace*' in order to minimise stress for their serving/veteran partner [11, 18, 20]. Mansfield et al.'s [11] study likened it to *walking on eggshells* (p492). Noted across the findings of six studies, was that the physical and mental demands felt from years of providing care, increased stress levels, caused frustration and ultimately, fatigue [2, 3, 11, 18, 25, 26]. The participants in Brickell et al.'s [26] study highlighted how time-consuming caregiving is and consequently, led to exhaustion and being emotionally drained. The burden and the sacrifice caused by a *sense of dependency*, was echoed in Murphy et al. [24] and Waddell et al.'s [25] findings (p43).

Beckham et al.'s [2] study of 58 spouses identified that caregiver burden increased over the 8-month period studied. In addition, a further attributing factor emerged: there were significant correlations between the caregiver burden felt and the severity of PTSD symptoms. Similarly, Allen et al. [1], Manguno-Mire et al. [10] and Brickell et al.'s [26] studies, found that serving/veteran partners PTSD severity was a reliable predictor of caregiver burden. As well as exploring the severity of symptoms and caregiver burden, Calhoun et al.'s [21] study included the level of veteran interpersonal violence; an area not examined in other studies. Findings showed that symptom severity was not solely attributable to caregiver adjustment/burden. There was a significant association between interpersonal violence and both caregiver burden and partner psychological adjustment.

As well as PTSD severity, engagement in serving/veteran partner’s treatment was associated with higher levels of caregiver burden in seven studies [6, 10, 14, 15, 18, 25, 26]. Within all seven studies, this was attributed to the hope and expectation of getting involved with their serving/veteran partner’s treatment plan; their serving/veteran partner’s symptoms would decrease and in turn, lessen the overall burden of care the spouses felt. Manguno-Mire et al.’s [10] study suggested that as spouse self-efficacy increased, the caregiver burden decreased.

Theme 2: Intimate relationships

Central to all people’s lives are relationships; they come in all shapes and sizes from casual acquaintances to family/blood connections to intimate relations (Miller, 2014). An emerging theme from the literature review relates to the intimate relationship between adult couples. Understanding intimacy is a complex concept that is multifaceted, with a range of components within it (Prager et al., 2013). Indeed, Miller’s (2014) explanation of intimate relationships are founded upon research findings from the fields of psychology, neuroscience, sociology, and from family and communication studies. Ben-Ari & Lavee (2007) identify at least seven explicit ways (highlighted in italics below) in which intimate relationships differ from casual acquaintances: *knowledge* of one another, which is often personal and sometimes confidential, is shared; the couple are often intertwined in that what one spouse does, affects the other, leading to *interdependence;* being caring, trusting and *responsive* to each other are fundamental qualities within the intimate relationship; *mutuality*, whereby the *‘I’* becomes *‘us’*, along with *commitment* to the relationship. Miller (2014) however, suggests that not all the above characteristics have to be present for intimacy to occur, just as there is no one type of intimacy since this varies between individual couples. Miller (2014) also acknowledges other influences such as culture, experience, human nature, and gender differences. The motivation to establish intimacy with others is part of a basic human need to belong. Baumeister & Leary (1995) suggest that for a caring and lasting relationship to function normally *regular ‘social contact with those whom one feel connected* is needed (p501).

‘*Intimate relationship’* was a point of discussion within seventeen of the studies [1, 5, 7-9, 11-13, 15, 17, 18-20, 22, 23, 25, 26]. Thandi et al. [22] recognised ‘*intimacy*’ as a key theme; however, this was the only study to represent the changes in relationship intimacy experiences, by dividing into two subthemes: physical intimacy and emotional intimacy. Three studies portrayed positive relationship views, all of which were noted to be from the participants' discussion of either their relationship prior to deployment and/or the onset of PTSD symptoms, or when the spouses' talked about their commitment to the relationship [3, 5, 9,].

Throughout all the studies, there was some degree of negative connotation concerning the spouses' relationship with their serving/veteran partner. Allen et al.'s [1] findings suggest that the serving/veteran partner's recent deployment and subsequent increase in PTSD symptoms was indirectly linked to negative marital functioning. Campbell & Renshaw [5] and Renshaw & Caska [12] also found similarities; initial negative spouse relationship satisfaction was reported on their serving/veteran partners' return from deployment but was not statistically significant. However, when revisited four to six months post return, the findings highlighted the severity of PTSD symptoms held significant negative association with service partners' relationship satisfaction. Overall, PTSD symptoms and their severity were a specific feature in five of the studies, all of which highlighted a major impact on the marital relationship [7, 8, 11, 13, 26].

One other contributing factor to the impact on the marriage relationship was domestic abuse, seen in Jordan et al. [8] and Mansfield et al.'s [11] studies. Mansfield et al. [11] reported that 10.6% of their participants were victims of verbal, emotional or physical abuse. Jordan et al. [8] found the prevalence of abuse by asking for the number of violent acts, including threats of violence over the previous year. For spouse of veterans with PTSD, there was greater incidence of abuse both as victims but also as perpetrators of abuse towards their serving/veteran partner.

Thirteen studies noted changes in personality, difficulties in communication and long-term withdrawal of the serving/veteran partner, ultimately leading to emotional numbing or an emotional disconnect [5, 7, 9, 11, 12, 13, 15, 17, 18, 19, 22, 25, 26]. Waddell et al.'s [25] study illustrated how intimacy problems surfaced, spouse experiences of emotional alienation arose from being unable to express or share thoughts and feelings with their serving/veteran partner. Renshaw and Caska [12] suggested the generalised symptoms such as social withdrawal is more easily misinterpreted by spouses as a reflection about them and/or the relationship, whereas physical symptoms were commonly linked to an illness and therefore posed minimal threats to the relationship. Nevertheless, this distancing and abandonment manifested in most of the studies as frustration with/or sadness and grief about the relationship changes. Brickell et al. [26] recognised the strain of the relationship as loneliness.

Thandi et al. [22] found that some participants discussed noticing a change in character in their serving partner, stating they were no longer like the person they married. This led to less affection and more arguments. Waddell et al.'s [18] findings noted that participants viewed their relationships as different to others, prompting the notion that their relationship was not a '*normal'* one. Both studies by Waddell et al. [18, 25] found that the spouses' felt there was a constant striving to intimately connect with their serving/veteran partner, this was in an effort to break down the barrier of emotional detachment. Verbosky and Ryan [17] and Thandi et al. [22] found that for some participants, the lack of intimacy enhanced the spouse's need to be nurturing and caring to reconnect. Sherman et al.'s [15] study reported that half of participants expressed loyalty to their serving/veteran partner and described the importance of providing emotional and behavioural support. Similarly, Waddell et al. [18] found that despite the feeling of not holding a *'normal'* relationship, there remained from the spouses a strong commitment and moral responsibility to the relationship. The acceptance of the impact on the relationship then assisted them in finding some deeper meaning.

This dedication to the relationship was mirrored in the findings of five other studies [3, 7, 9, 11, 19]; most participants reported an ongoing inner struggle about whether to stay or leave the relationship. Factors such as children, domestic abuse were listed as reasons to leave; however, these were often overruled by guilt, love, a sense of obligation, and fear that their serving/veteran partner would worsen if they left. Some participants in Iniedu's [7] study felt that there simply was no option to leave. Longevity of the relationship was also a consideration which featured in both Allen et al. [1] and Wood's [19] studies. Data gathered from Woods's [19] study showed that those participants with longer relationships were more likely to remain in the marital relationship, believing that the relationship was positive, whilst those with younger marital relationships, predominantly viewed their relationship with more negativity. Thandi et al. [22] and Martinez [23] identified longevity, not by the length of time in the relationship but of a positive relationship that established over a period of time, post diagnosis.

Theme 3: Psychological and psychosocial effect on the spouse

Seventeen studies reported on the psychological and psychosocial impact experienced by spouses of either serving personal or veterans with PTSD or other mental health illnesses [2, 3, 7-10, 16-18, 20-27]. Psychological distress was a predominant finding throughout the studies. Manguno-Mire et al. [10], Beckman et al. [2] and Iniedu [7] all indicated that the greater the severity of PTSD symptoms experienced by the serving/veteran partner, a greater intensity of psychological distress, dissatisfaction and anxiety was experienced by the spouse. Manguno-Mire et al. [10] reported that of the overall psychological distress scores, inclusive of the individual measures for anxiety, depressive and somatic symptoms were high in all the areas. Fifteen percent of the 89 spouses stated frequent suicidal ideation, suggesting a severity of symptoms that might warrant clinical intervention. In addition, 25% spouses described that at some point in the six months prior to the study, they had received mental health treatment. Similarly, Brickell et al. [26] identified depression which included feeling depressed or sad, crying a lot or suicidal ideation, as a key theme for 30% of participants. Iniedu's [7] study found that all spouses experienced secondary trauma because of their serving/veteran partners' PTSD symptoms and were in receipt of medication and/or face-to-face therapy. Five studies [9, 18, 21, 24, 27], reported the impact of living with a serving/veteran partner with PTSD. All highlighted the negative impact on the spouses' mental health, by identifying the stress related symptoms they had experienced. In Jordan et al.'s [8] study, there was a significant difference between the participants whose serving/veteran partners displayed symptoms of PTSD to those who did not. The spouses of those with symptoms reported feeling close to a nervous breakdown, although none reported receiving specific mental health treatments.

Manguno-Mire et al.'s [10] study further identified predictors specific to the levels of psychological distress experienced. Psychological distress was found to decrease when there was greater involvement with the serving/veteran partner's care and treatment. However, if there had been a recent episode of mental health treatment or an increased perceived threat from the serving/veteran partner's PTSD symptoms, the psychological distress felt by the spouses was increased. Martinez [23] examined attachment style and the level of attachment within the relationship and the subsequent effect on psychological and physical symptoms. He found that caregivers with an anxious attachment style were more likely to experience physical symptoms and higher incidents of physiological stress than those with a non-anxious attachment style.

Manguno-Mire et al.'s [10] study identified that 60% of participants reported that their serving/veteran partner posed a physical threat to their wellbeing. The threat and psychological distress are also demonstrated in other studies [16, 23, 24]. Temple et al. [16] stated that the anxiety felt was exacerbated by *not knowing what type of mood their husbands were going to come home in or what emotions they would bring through the door* (p170). Similarly, Murphy et al. [24] identified the volatile environment where some participants likened it to the metaphor *walking on eggshells*; albeit a different interpretation of the same metaphor highlighted in the earlier theme. The '*not knowing'* and loss of predictability invariably led to hypervigilance and hyper-attentiveness which was documented in nine studies [3, 9, 18, 20-22, 24, 25, 27]. Remaining hypervigilant and hyperattentive to the actions and moods of their serving/veteran partner has been aligned with the need to find a resolution and an attempt to create peace and healing [9]. Yambo et al. [20], and Johnstone and Crogan [27] findings, however, suggest an opposing view of the emotionally unstable environment, stating it results in increased feelings of stress.

As well as spouses being hypervigilant and hyperattentive to their serving/veteran partner's needs, seven studies [16-18, 22-25] highlight a distinct level of responsibility felt by the spouse. Fear for their serving/veteran partner, guilt linked to the inability of being able to rectify their serving/veteran partner's difficulties and emotional pain, led to feelings of self-hate and blame. Jordan et al.'s [8] comparison study of levels of problems in the families of Vietnam veterans with or without PTSD, suggested that a spouse with a serving/veteran partner who had PTSD had substantially higher demoralisation scores and was significantly more likely to report lower levels of happiness. Lyon's [9] study demonstrated the move from the early phases of the relationship, referring to spouses' feelings being '*compatible with the honeymoon period'* towards the mid phases, where comprehension of the severity of their serving partner's PTSD and subsequent impact on the relationship are realised. The feelings reported were numerous and varied from happiness and laughter to frustration, resentment and/or bitterness, guilt and humiliation; being out of control and trapped; grief and loss to pride for both them and their serving/veteran partners. A finding from Temple et al.'s [16] study simply described the relationship between spouse and serving partner as a '*roller coaster'* (p170).

This myriad of feelings continues to be identified throughout a further six studies [3, 7, 17, 24, 26, 27]. The most negative connotations are described by Brown [3], who observed *that anger was used 103 times to describe their feelings in comparison to love at 32 times* (p250). While Johnstone and Crogan [27] highlighted the increased level of anxiety and difficulties *because of the sense of constant worry that some participants felt, particularly when (their) partner expressed and engaged in suicidal ideation with intent* (p65). Verbosky and Ryan [17] state that the spouses experienced an overwhelming sense of helplessness and uncertainty as they were unable to formulate plans to effectively deal with the symptoms and situations they faced, finding it difficult to be assertive at the appropriate time. In contrast, Iniedu [7] and Johnstone and Crogan [27] suggest that there was evidence of empowerment brought about by the spouses' struggles to cope and hold everything together, indicative of the concept of post-traumatic growth (Tedeschi and Calhoun, 1996). The concept of post traumatic growth suggested by Tedeschi & Calhoun (1996) recognises that the struggle to overcome the distress and challenges arising from the exposure of a traumatic event, brings about psychological and spiritual growth through a heightened sense of power and mastery with a greater sense of meaning and valuation of life.

Amongst the extensive array of feelings identified and the change in behaviours required because of the serving/veteran partner's symptoms, a loss of self was identified in five of the qualitative studies [3, 18, 24, 26, 27]. Brown's [3] study illustrated that participants had exhausted all their intrinsic resources and faced a lack of normality, meaning many had neglected responsibility for themselves and indeed, lost themselves in a sense of powerlessness. Similarly, Murphy et al. [24] described one of their emerging themes as the *loss of congruence with own identity* (p4). Whilst Brickell et al.'s [26] study acknowledged the loss of self from an emotive perspective, the loss of physical self-care was also recognised in their analysis.

The transference of loss of self into home and work life was evident in nine of the studies [3, 7, 8, 16, 17, 18, 22, 26, 27]. In most, this psychosocial element was identified as *tremendously stressful* (Brown [2] p236). Iniedu [7], Temple et al. [16] and Verbosky and Ryan's [17] studies identified that managing either their serving/veteran partners' symptoms and/or their own stresses, had significant ramifications on daily life and in some cases, had taken over completely. Three studies [16, 18, 26] suggested that the adaptations and modifications required to daily life, meant that the spouses had to adjust work hours and, in some cases, reduce hours or quit their job. Thus, leaving a sense of profound distress that they were unable to pursue life with the same level of commitment in their professional and personal roles. In addition, there was also the identification of children within such scenarios. Brown [3], Jordan et al. [8] and Temple et al. [16] found similarities in the concern voiced, regarding the impact on children and their subsequent behaviours.

It could be suggested that because of the negative feelings felt by most spouses within the studies there would be correlation with friendship, socialising and external support (discussed in Theme 4). Nine studies explicitly documented findings highlighting friendship and socialisation [3, 8, 16-18, 23, 24, 26, 27] Waddell et al.'s [18] study briefly highlighted the spouses' social isolation, whereas Temple et al.'s [16] study explored this in greater depth. The findings suggested that if the serving/veteran partner struggled to leave the house, this had an impact on the spouse's ability to socialise, leading to difficulties in maintaining existing friendships or making new ones. Likewise, Brown [3], Verbosky and Ryan [17] and Brickell et al.'s [27] studies indicated that participants merely gave up on any recreational or social activities. Verbosky and Ryan [17] suggested that 19 of the 23 participants felt that they were no longer able to make meaningful contributions to others, voicing a sense of worthlessness. Similarly, Murphy et al. [24] and Brickell et al.'s [27] participants felt others (family and friends) who were not living the same experience, simply did not understand. In contrast, Jordan et al.'s [8] quantitative study of 376 participants found no significant difference in the levels of social isolation.

Theme 4: Mental health service provision.

Mental health service provision emerged as a theme within eleven of the papers [3, 4, 11, 15, 16, 18, 22, 24, 25, 26, 27] albeit very briefly in three papers [22, 24, 27]. The ability to liaise with medical or other trained professionals with experience of dealing with PTSD was reflective of the spouses' perceived individual needs [3, 11, 24]. Greater involvement in the serving/veteran partner's care and treatment by the spouse was also noted. Mansfield et al. [11] and Temple et al.'s [16] studies also identified mental health services; namely, requests for help or receiving care. The spouses' main aims were to gain information in order to inform their caregiving and receive constructive feedback on how they were managing. Share information that may not have been disclosed by their serving/veteran partner or merely share their experiences of daily life. It is evident from the spouses' experiences, however, that these requests were not always received positively by the mental health services [16]. In contrast Murphy et al.'s [24] findings highlighted the value participants felt by being able to share experiences and gain expert in-depth knowledge from specialist practitioners.

Serving/veteran partners who had a clinical diagnosis or had in the past or were currently receiving treatment for their illness was noted in 16 studies and psychological distress was noted in 17 studies [2, 3, 7-10, 16-18, 20-27]. Six studies [2, 7-10, 18, 27] recognised the spouse themselves needing to seek help or treatment for stress related symptoms. Johnstone & Crogan [27] voiced a *sense of being invisible, forgotten and overlooked* when it related to their serving/veteran partners' treatments (p45). Mansfield et al. [11], Waddell et al [18] and Waddell et al's [25] studies described similar feelings; although related to the attempt at seeking help for themselves, feelings of isolation and invisibility were recognised in comments such as '*in general family members seem to be left out'* and '…..*but there is no help for the family'* (Mansfield et al. p419).

In Buchanan et al [4], Temple et al [16], and Johnstone & Crogan's [27] studies, spouses were cautious about reaching out to others, their partners were serving military personnel and access to mental health care services differed to that offered to veterans. Buchanan et al.'s [4] quantitative study found that nearly 25% spouses highlighted stigma towards PTSD, which is echoed in the majority of narratives gathered by Temple et al. [16]. In addition to the stigma, the narratives also highlighted the mixed messages received from military units. Positive messages surrounding PTSD were promoted through adverts in and around the military base. However, direct actions such as accessing services sent *a negative message that the marine was weak* and reactions received when the serving/veteran partner tried to access services was that *a spouse's cry for help doesn't matter* (Temple et al.,[16] p172). Mirrored in Brown's [3] study, spouses voiced similar feelings of being *silenced by the institution; by having no voice* (p240). A further complication to accessing help and support from mental health services and professionals was the belief that doing so, jeopardised the future career prospects for their serving/veteran partner [4, 11]. One narrative in Temple et al.'s [16] study differed, however; this was from a spouse who was a serving member of the military and whose experience varied as a result of being part of the organisation. For those spouses who did have experience of liaising with services, there were a couple of positive comments raised pertaining to service provision. The majority of comments made however, were critical of the services provided. Mansfield et al.'s [11] study conveyed disappointment at service funding cuts, poor facilities with low levels of staff and long waiting times. Whereas other criticisms were underpinned by the difficulties in identifying available services and then having the inability to access them for reasons such as income, location, and competing demands on time [11, 15, 26]. Brickell et al. [26] identified a theme dedicated to '*Lack of Access to Services'* which was described by approximately half of the participants. This included: a shortage of service information; being '*run around in circles'*; difficulty with appointment scheduling; travel issues and lack of funds or no funds from a caregiver stipend.

Theme 5: Spouse's knowledge and management of symptoms.

Six of the studies highlighted spouses' knowledge around PTSD and the management of symptoms when they occurred [4, 15, 16, 20, 22, 24]. Buchanan et al.'s [4] study specifically focused on the awareness of PTSD from the spouse perspective. Buchanan et al. [4] undertook a critical incident survey which included the question *How would you know if your spouse/partner needed treatment for PTSD?* (p747). The findings suggested that two thirds of spouses had received no formal training on PTSD but most had accessed informal sources to learn about PTSD. Media resources such as movies, news broadcasts or internet were identified as primary sources. Murphy et al.'s [24] study suggested that as a result of a sense of responsibility, practical learning about what to do and say was valued by the participants. Temple et al.'s [16] study presented one spouse who differed from the other spouses; she voiced a clear understanding and underpinning knowledge of PTSD symptomology which she attributed to the in-house training she had received as a serving member herself.

Buchanan et al.'s [4] study further explored spouses' knowledge and understanding about PTSD causes: a fifth of spouses were able to identify the causes relating to their serving/veteran partners. When considering the presenting symptoms of PTSD, 21% of spouses were able to list one or two symptoms and 25% were able to identify three or more symptoms. 12% of participants declared they had little knowledge of the presenting symptoms [4]. While Murphy et al.'s [24] study did not specifically explore individual knowledgebase, it highlighted the need to share experiences with peers in similar situations, in order to gain reassurance and increase confidence in their understanding.

One of the key themes emerging from four studies [15, 16, 20, 22] was the spouse being unprepared to handle the condition and/or deal with the complexity of the symptoms. Thandi et al.'s [22] participants *described how they felt ill-equipped to perform the role as caregiver* (p2). Sherman et al. [15] stated that over a third of participants highlighted a lack of understanding regarding their serving/veteran partners' functioning, which then became a barrier to communication between the couple. Most participants in Temple et al. [16] and Yambo et al.'s [20] studies stated they had never been provided with any information about PTSD, either before or after their serving/veteran partners' deployment. Consequently, were unable to identify whether their serving/veteran partners had PTSD. The lack of information around PTSD, resulted in spouses doubting their relationship and own sanity. They believed they were to blame for their serving/veteran partners' destructive behaviours; for some spouses, this belief had exceeded 10 years.

Summary of literature review.

Following completion of the review, it emerged that there was a limited range of papers whereby the primary focus was on the experience of the spouses of serving military personnel. As explained earlier, the parameters of the search had to be widened to include spouses of veterans and the time scale was broadened to include studies undertaken post the Vietnam conflict. On reviewing the available literature, five predominant themes emerged. Whilst themes were identified, it was sometimes difficult to separate findings into one distinct theme since, in most cases, they often interlinked.

The notion of caregiving burden was evident in several papers. Within most studies, caregiver burden was viewed negatively. Evident in the literature was how the spouses' level of burden increased at times when their serving/veteran partners' symptoms of PTSD where at their most severe. Likewise, when their serving/veteran partners' PTSD symptoms were minimal and they were responding well to an aspect of treatment, the level of caregiver burden felt by the spouses lessened.

The impact on the relationship was also evident and emerged as another key theme. In the studies involving veteran spouses, most spouses were married and had been a part of military life whilst their serving/veteran partners were serving. The toll on the relationship was tangible, with many spouses stating that they had - at times - felt like leaving the relationship. Many spouses blamed themselves for the problems faced in the relationship. In some of the studies, spouses' early relationship recollections prior to their serving/veteran partners PTSD were taken. These were reflected on with fondness and love akin to the *'honeymoon period'*. Once symptoms such as emotional detachment entered the relationship, the relationship became much harder, and problems began to escalate. Many spouses felt a sense of responsibility to stay and '*stand by their man'* and, in all but one of the papers, the spouses remained in the marriage. Some of this was out of fear that their serving/veteran partner would hurt themselves or become worse. For some, it was out of loyalty, for some it was guilt about deserting them in their time of need and for some it was love. Very often, it was mixture of all these reasons, meaning the spouse no longer viewed their relationship as *'normal'* anymore.

The decision to stay had ramifications psychologically and psychosocially on the spouse. Throughout many of the studies, it was evident that they found coping with everything - family, home, work and their serving/veteran partner - stressful and anxiety provoking. This stress led to many spouses seeking treatment for their own mental health needs. Spouses described being peacekeepers to prevent triggering their serving/veteran partners' symptoms. Spouses became hyper-vigilant and hyper-attentive to their serving/veteran partners' behaviours and needs which, ultimately, placed greater strain on themselves. Spouses also described how their lives had changed socially; some felt forced to reduce their working hours, withdrawal from maintaining existing friendships and/or making new acquaintances due to the caregiving commitments for their serving/veteran partners.

A small number of studies explored what knowledge spouses held about PTSD or mental health issues. For the majority, no formal training or guidance had been received and most of the spouses had used media such as films, internet and campaigns to make the connection between their serving/veteran partners' symptoms and mental health issues. Mixed messages were also highlighted; however, this was predominantly from those studies where the serving/veteran partner was still serving. For these spouses, there was an element of fear about upsetting the '*applecart*'; they were frightened that disclosing their serving/veteran partners' symptomology or seeking help would affect their serving/veteran partners' career prospects. Furthermore, that their serving/veteran partners would be stigmatised by a diagnosis, despite widespread use of flyers and advertisements stating that it was '*okay to talk'*. Spouses felt torn between the need to help their serving/veteran partner verses jeopardising their partners' career. Many spouses felt invisible and isolated with nowhere to turn for support for either their serving/veteran partner or themselves.

Barriers to mental health service provision were also recognised; for some of the USA studies, it was the financial burden of travel to attend services, for others, accessibility and/or time along with not even knowing where to go in the first instance. For those who had accessed mental health services, most expressed that the experience was far from ideal; staff shortages, lack of funding, long waiting times and poor facilities meant disappointment once access was finally gained.

Limitations to current research and systematic narrative review.

Employing a systematic search strategy ensured the searches were transparent. Despite adopting the systematic approach, I was only able to yield a limited number of contemporary papers specific to the military spouses. The lack of peer reviewed papers over recent years internationally, provided the rationale for the inclusion of earlier studies. These were identified by increasing the time parameters and by executing a reference and citation search on the papers found; again, this yielded only a few earlier papers for inclusion. From the twenty-seven studies identified, nineteen of the papers focussed primarily on spouses' experiences. However, even fewer specifically pertained to the spouse experiences of serving personnel; the majority were spouses of veterans. Whilst the spouse experience of veterans produced some similarities, it must also be acknowledged that there are limits to the transferability to serving personnel. The main limitation being that veteran's reside outside of the military organisation and therefore provision of services, funding and access differ.

As my study was specifically exploring experiences of UK military spouse, the ideal scenario would have been to review papers focused specifically to the UK. A major limitation to review was the distinct lack of studies carried out within the UK; only three of the papers identified in the searches made any reference to the UK. From the three papers identified, two focussed on spouses of veterans; the only paper focusing on spouses of serving personnel utilised secondary data gathered from a questionnaire in a different study. Owing to the cultural complexities across military organisations, studies conducted with westernised military spouses published in peer reviewed English language journals were deemed appropriate to expand this review. A noteworthy point, however, must be acknowledged when analysing the findings. The differences in deployment terms and healthcare systems of other westernised countries are markedly different to the UK and would make the transferability of some of the findings to the UK problematic.

A further limitation surrounded the specifics of the mental health issue itself. The emphasis in most of the included papers was specific to either experience of service personnel directly after deployment with PTSD or veterans who were no longer serving with PTSD. PTSD was the single focus for many of the papers; only six papers referred to other mental health issues as well as PTSD. For my research, the focus is not specifically PTSD but inclusive of all mental health issues. Likewise, the mental health issue did not have to be directly associated or because of a specific conflict or war experience. Many of the papers in the review made specific links to war as a precursor to the PTSD. The papers gathered made links to either post service in the Vietnam conflict or after serving OIF and OEF conflicts. It is noteworthy that the conflicts were fought more than 25 years apart and also in different countries and terrains. They were fought by very different means in that Vietnam used predominately guerrilla warfare tactics with a largely ~~an~~ unseen enemy whereas OIF and OEF were more conventional in the type of warfare deployed; for example, soldiers faced a modern military organisation with greater use of armoured and air support. These differences suggest that the experiences and exposure faced by those serving would have been markedly different.

This review is focused specifically on spouses of military personnel or veterans who have served and therefore is not inclusive of the wider literature exploring those spouses' experience outside of a military context. This focus was intentional due to the differences in mental healthcare provision for UK serving personnel. Whilst UK provision is aligned with National Health Service (NHS) policy it is provided in-house by Defence Medical Services (DMS), outside of the NHS. When considering non-military civilian couples, the majority have and will access the same NHS provision - such as GPs - which has its advantages such as information sharing between professionals for the provision of holistic family care. Whereas, with most residing military couples, the serving member accesses DMS for all their medical needs and the spouse accesses NHS provision. This separate provision provides a potential barrier to information sharing and access for support (Cornford et al. 2013; Gray et al. 2016).

It is widely acknowledged that there are a range of programmes/interventions that aim to offer support to spouses who find themselves experiencing life alongside a serving/veteran partner who has a mental health issue; for example, Spencer-

Harper et al.’s (2019) study of group psychoeducation support. As a result of such programmes/interventions, it is understood that grey literature exists by wider professional, charitable organisation and government publications. Only peer reviewed research was included in this review which meant that all grey literature was excluded. Two further exclusions were domestic violence and secondary PTSD. This was purposeful, as the aim of my study was to explore the experiences of spouses and not the outcome resulting from the experience. It is widely acknowledged in the USA, that the potential outcomes of living with someone with PTSD, are a higher incidence of domestic violence (Kwan et al., 2020) and a higher incidence of secondary PTSD for the spouse (Dekel et al., 2016). It was felt that the inclusion of such studies would detract from and overshadow the limited peer reviewed literature available.

2.3 Chapter conclusion

To conclude, the systematic narrative literature review identified a huge gap in the literature; specifically for those spouses residing in the UK. Spouses of veterans or serving military personnel have been studied but in different contexts and are culturally different to that of this study. The majority of the papers reside in the USA [22], with minimal papers from the UK and Australia [3 and 2 respectively]. While there was a near equal divide between quantitative or mixed methods and qualitative [11+2 respectively and 14], only 9 studies used interviews as the data collection method. Thus, posing a further limitation as the majority of data collected, lacked the rich, in-depth nature required to explore spouse experience. It is also worth observing that there remains a gap in the literature regarding the number of specific studies focusing on military spouses of serving personnel. Most of the studies focused on spouses of veterans, with the majority being women partners but similarities were noted.

The findings from the review have some implications for policy, practice and research focusing on the military spouses’ experiences of living alongside their serving/veteran partners during a mental health issue. Care burden from both a psychological and a physical/practical aspect was evident, as was the longevity of their partners’ mental health issues. All led to a long-term impact, where most military spouses felt they were more like care providers than partners. The impact was also felt in the intimate relationship between military spouse and partner; difficulties in communication and emotional numbing were identified. However, dedication and commitment to the relationship was also noted. For the military spouses themselves, there was a sense of *'loss of self'* as a direct result of caring for their partner. In addition, there was a felt sense of being invisible and/or overlooked by the mental health services; when what was required was inclusion in order to gain information, so that they could better manage their partners' care. Understanding the experiences, perspectives and difficulties of military spouses whilst living alongside their UK serving partner during a mental health issue will assist in better understanding of how their interactions can support or implicate their partners' recovery. Inclusion from services needs to be considered as a protective factor for both the military spouse and their serving partner.

The review's findings: namely, the gaps in current research surrounding spouses of serving personnel with specific focus on mental health, the lack of UK studies and further, that the methodology of the existing UK study utilised secondary data from a previous studies questionnaire, enabled me to review and refine the direction of my research to fully address the research aim and contribute new knowledge to this important topic area. In addition, exploring the literature has informed some elements of my conceptual framework discussed in chapter 3. Moving forward then, the research aim, and objectives were:

To explore the experiences of military spouses living alongside their UK serving partner during a mental health issue.

To achieve this aim, the research objectives were refined to:

- investigating, through a biographical approach, the experiences of the military spouse whose UK serving military partner had sought support or treatment from mental health healthcare provision.

- explore the experiences of the military spouse during their UK military partners' mental health issue and to better understand their role in this process and its effect on the relationship.

- explore their experiences to develop a deeper understanding of the challenges and enablers which help military spouse in their relationship with their UK serving military partner during a mental health issue.

- use the participant experience to develop a deeper understanding and make recommendations for future research and for practice, in supporting military spouse and the care of serving personnel with a mental health issue.

3 Chapter 3: Conceptual thinking

3.1 Introduction to chapter

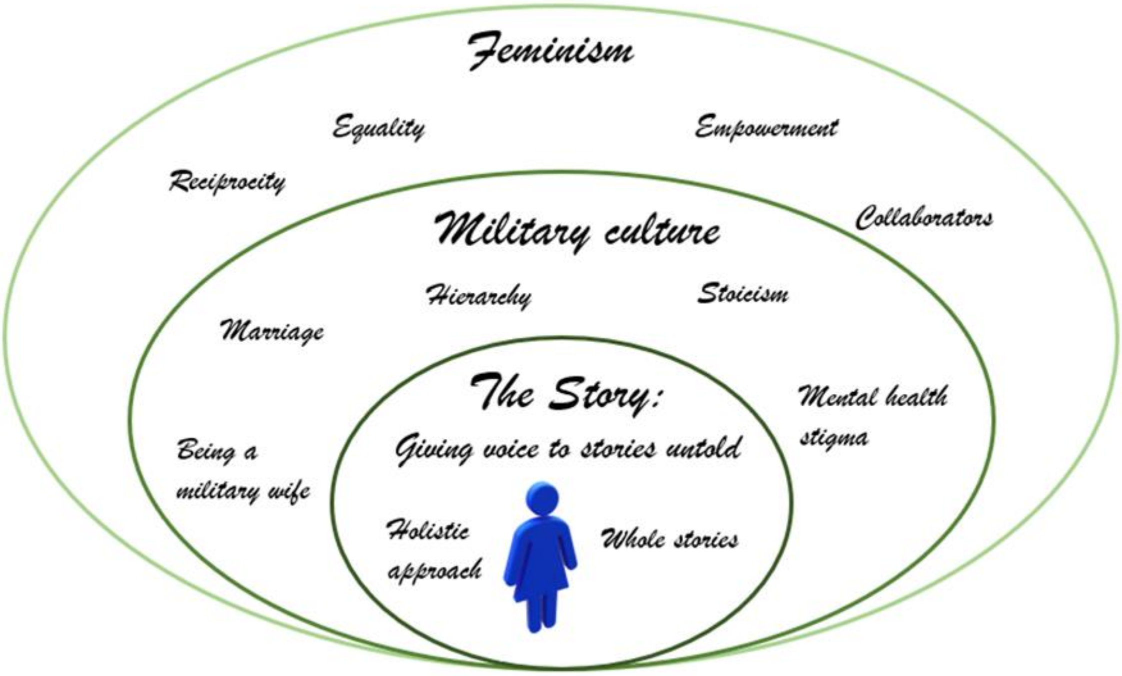
This chapter presents the conceptual thinking that informed the development of this thesis. The function was to illustrate the conceptual thinking based on my experiential knowledge and understanding, the literature review findings and my research aim, objectives and question.

3.2 My conceptual thinking

There is much discussion differentiating or indeed conflating the terms theoretical and conceptual frameworks (Maxwell, 2013; Collins and Stockton, 2018). Collins and Stockton (2018) suggest that within qualitative methods literature there is a blurring of the lines between the two; for some, they are viewed synonymously (Maxwell, 2013) and for others, there are stark differences (Merriam and Tisdell, 2016). Collins and Stockton (2018) surmise that a theoretical framework focuses on the theory or theories used in the study that communicate the innermost values of the researcher, thus providing a clear lens for the direction of the study and new knowledge. Whereas a conceptual framework serves as a map showing how all the literature works together to shape the study. It provides a line of reasoning about why the topic matters, and why the chosen approaches to undertake the study are informed, reasonable and rigorous (Ravitch and Riggin, 2017). Thus, the conceptual framework aids the researcher in understanding the phenomena rather than predicting outcomes (Jabareen, 2009). A conceptual framework does not pre-exist; it is something that is built; created from a combination of experiential knowledge, prior research and theory (Maxwell, 2012). Because the building of a conceptual framework in qualitative research continues to lack clarity and systematic method (Jabareen, 2009), I have chosen to share my initial conceptual thoughts using text and a pictorial image to assist readers' understanding (Fung, 2016). My thinking arose from the literature review findings, my experiential understandings, the research aim, objectives and research question.

Figure 2 illustrates my conceptual thinking. Moving beyond individual concepts my conceptual thinking facilitated a challenge to current theory and inform the study, along with a lens through which the methodology and data analysis could be viewed. Three theoretical concepts were identified as the foundation from which to explore military spouses' experiences of living alongside their serving partners' mental health issue: the story, military culture, and feminism.

Figure 2: Image of my conceptual thinking



3.3 Importance of the story

The literature concerning military spouses is very often an adjunct within veteran or serving personnel studies (Jordan et al., 1992; Beckman et al., 1996; Riggs et al., 1988; Calhoun et al., 2002; Sautter et al., 2006; Sherman et al., 2008; Allen et al., 2010; Buchanan et al., 2011; Campbell & Renshaw, 2013), with minimal studies identifying military spouses at the heart. The marginalised nature in which women and their first-person stories within conflict and war narratives is also recognised by Parashar (2013), Harel-Shalev and Daphna-Tekoah (2016), and Caddick (2021). McAdams (1997) suggests storytelling provides an opportunity for individuals to share and make clear to another person, something about themselves and their untold story, which is important, allowing them to be seen above the varying roles (wife, mother, husband) that they undertake. Furthermore, Parashar (2013) makes the point that the inclusion of ordinary people's stories of war, challenge dominant narratives and disrupt the assumptions made about women's role in war and conflict.

Given this, the spouses' stories needed to be central to this research. Moreover, it was paramount that the untold stories of military spouses were considered as a whole and not just subject to the extrapolation of themes or categories from within and across the narratives. Whilst I recognise the value of identifying themes or categories to highlight the sociocultural characteristics of personal narratives and to find a common voice in their shared yet different experiences, I was also compelled to provide representation of the participants as individuals. To represent them without their stories simply being the subject of dissection for their parts from which more transferable conclusions can be drawn (Andrews et al., 2013. p65). I see one of my roles as researcher as a conduit to ensure that their voice is at the forefront and that their stories are allowed to be told. Indeed, when embarking on such research inquiry, Frank (1995) spoke of a moral duty *to listen to those who suffer* (p25). Furthermore, Frank (2009) proports that every aspect of life needs narration, in that, to be human is not just to live but to reflect on life by speaking of it to multiple audiences in multiple ways during our lives. It is theorized by some that story telling is indeed a fundamental human need, an evolutionary advantage that has made humans what they are (MacIntyre, 1984; Mishler, 1999; Bruner, 2002; Boyd, 2009).

Similar to Plummer (2006), and because I was afforded the opportunity to carry out this research, I felt duty-bound to aid in the development of a *sociology of stories from personal experience narratives of intimate life* (p6) so that such stories can be used to humanise the darkness (Kermode, 2000). This allowed me to be less interested in the analysis of formal structures within the stories - such as plot, language or discourses - and more *involved with the tale told by a person about the self* (Plummer, 2006, p24), the sensitive perceptions of the experience and how they perform in the wider cultures and societies they inhabit. This facilitates the stories to become narrative resources for others who want to voice their experiences to begin the process of healing but often struggle to do so.

While the need for whole stories as well as the sum of their parts has been identified, the cultural influences and social context cannot be disregarded. Indeed, insight and exploration into the links between individual stories and the wider sociocultural context is required to provide a backdrop that will support and inform a sociology of stories. This is discussed further in the methodology chapter 4.

3.4 Military culture

I was acutely aware of the presence of a military culture existing, despite never having resided in military accommodation or having other military spouse friends. As an NHS health practitioner who had worked as a sexual health advisor (SHA) alongside the military delivering a service directly to recruits entering the armed forces and soldiers on camp, I saw first-hand the journey of becoming a soldier. This was not always compatible with my own values and beliefs, and I emotionally wrestled with some of the aspects within basic military training. As a military spouse the experience was often one of feeling second place to the organisation. At times, this placed both a physical and emotional strain on the relationship with my serving partner, especially when relationship/family commitments were cancelled at short notice. A few years later, when faced with my husband being deployed to Afghanistan, I was able to appreciate the need for the soldier's military training so when in the army, the soldier comes first.

Embarking on my doctoral journey, my experiential knowledge of seeing and experiencing differing positions as a health practitioner working in a military context and as a military spouse placed me in a position to see both sides of military culture. I felt first-hand the complexities imposed by military culture and the frustrations of military life but also had an insider view of how the 'soldier' is enculturated and could understand why such a military culture needs to exist. These nuances needed to be explored theoretically. To offer some illustration of the different elements within military culture of which I was acutely aware. Whilst military families face the many challenges present in civilian families, they also contend with a range of unique situations that others seldom face (Mancini et al, 2020). For military families, military life creates a culture that is unique to them. The existence of military culture is widely documented in the literature (Segal, 1986; Murray, 1999; Drummet, et al., 2003; Lucier-Greer, et al., 2015; Finnegan et al, 2014.; O'Neal, et al., 2016). From a historical perspective, Murray (1999) defines military culture as

> *'the ethos and professional attributes, both in terms of experience and intellectual study, that contribute to a common core understanding of the nature of war within military organizations'* (p27).

This definition, however, only recognises the organisation and is void of any recognition of the military family who very often reside alongside the serving person. Typically, over the years, many scholars have depicted military culture as hierarchical, disciplined, male dominant and competitive; it accentuates *'all things* *male'* and traditionally expresses hegemonic militarised masculinities (Hale, 2008; Sasson-Levy & Amram-Katz, 2013; Gray, 2015; McAllister et al., 2019; Kieran, 2021). In contrast, Segal (1986) identified both the family and the organisation using the term '*greedy institutions*' to describe how the two entities place demand on the serving person. Indeed, Moelker et al. (2015) suggests that increasingly, the serving person has become trapped between the two. '*Greedy institution'* was not a new term, as Coser (1974) had defined the term as '*a pattern of absolute devotion'*. Historically, for the armed forces under the institutional model, dominance prevailed, whereby it was expected that '*duty was meant to override love*' (Moelker et al, 2015, p11). However, Moskos (1977), recognised the inclusion of the serving person's family, suggesting they were viewed as part of the military community; that their private family life was synonymous and not separate to military life and, to that end, they all played a part in military life. These beliefs have preceded to embody what military enculturation is today.

Stoicism

One of the corner stones within military culture is stoicism and it is entrenched in all types of military organisation. It is a military persona which expects an individual to control their outward emotions and is taught from the first day of admission into the armed forces (Gabriel, 1988; Grigorescu et al., 2009; Shields et al., 2017). The last twenty years has seen a plethora of studies observing military training in which hypermasculine attributes such as strength, aggressiveness, dominance and stoicism are encouraged to prepare soldiers for combat and instil allegiance to selfless sacrifice for the sake of the group (Morgan, 1994; Keegan, 1994; Higate, 2000, 2001; Brooks, 2010; Fox & Pease, 2012; Gray, 2015; Shields et al., 2017). Shields et al.'s study (2017) illustrated such mastery and stoicism through a participant quote:

> *'There is the acceptable emotion for a man, sort of anger; you can express that by fighting or by yelling and that's about it. The rest of the emotions, they say to you in the military context again, it's your personal problem; bottle that up inside. Do not go telling other people about it because you are weak if you do*' (p219).

Other scholars also recognise this deeply held belief, suggesting that it is stoicism that inevitably impacts on help seeking, since military personnel feel they should be able to cope, work out or hide their personal struggles (Shields, 2016; Keeling et al., 2017; Taylor et al., 2019; McAllister, 2019; Kieran, 2021). Whilst this determines a clear direction, a dichotomy exists, in that some emotions are deemed acceptable. Those emotions linked to the experiences within the '*brotherhood*' whilst on operations where someone has been injured or killed is accepted and perceived differently within the broader military environment (McAllister, 2019). However, if the underlying cause is personal (missing their wife or family), it is not shared with others through fear of appearing vulnerable (McAllister, 2019).

The process of enculturation involves the constant suppression of emotions which progressively leads to a soldier's stoic nature. It requires the soldier to confront, repress and disregard biological signals; to flee from fear or repress crying out of pain or grief (Mejia, 2005; Basham, 2008; Fowler, 2010). Such enculturation is pronounced in the recruitment/promotional materials such as '*We will find a way*' (Canadian Special Operations Forces Command, 1CANSOFCOM, 2017) and in the repeated infantry rhetoric, such as '*pain is a sign of fear and weakness leaving the body*' and '*suck it up, and soldier on*' (Shields et al., 2017, p216). Such repression enables military personnel to become hardened to the realities of life and war, and to act with discipline, restraint and self-control but without emotion whilst undertaking difficult tasks that would be unthinkable to the civilian population (Grigorescu et al., 2009; Gray, 2015). It is suggested that such a philosophy is crucial to the functioning of the modern military (Grigorescu et al., 2009; Shields et al., 2017), giving a sense of agency and belonging (Gabriel, 1988).

The hierarchical nature of the military also ensues stoicism throughout the ranks. The military structure dictates that the lower ranking personnel follow the orders of senior ranks. As such the authoritative power held by the senior ranks enables the suppression of individual opinions and desires through strict discipline of those in lower ranks (Grigorescu et al, 2009). To summarise, Epictetus the Greek Stoic philosopher (b. 55-d. 135 CE) purports:

> *'Sick and yet happy, in peril and yet happy, dying and yet happy, in exile and happy, in disgrace and happy'* (Cited in Russell, 2013).

Mental health stigma in the military

In some cases, repression and internalisation of personal feelings can manifest in mental health issues. However, having a mental health issue would display a sense of vulnerability and/or weakness; something that, as previously discussed, deviates from what is expected within the military. This conflict invariably incites discrimination related to mental health in that mental health issues are perceived with an element of disgrace.

Numerous studies and departmental statistics identify the prevalence of mental health issues within the military (Iverson et al., 2009; Fear et al., 2010; MOD, 2020; Goodwin et al., 2015; Frank et al., 2018; Moradi et al., 2021). However, it is suggested that only a small proportion of serving personnel with a mental health issue will access mental health services (Hoge et al., 2004; Hitt, et al., 2020; Reger et al., 2020). Indeed, it is estimated that up to 60% serving personnel with a mental health illness will not seek treatment (Smith et al., 2007; Sharp et al., 2015; Hom et al., 2017). Multiple military studies point to stigma as one of the main barriers and is greater than any other reported logistical or practical barriers (Hoge et al., 2004; Stecker et al., 2007; Iverson et al., 2011; Keeling et al., 2017; Coleman et al., 2017; Bovin et al., 2019; McGuffin, 2021). Furthermore, illness-related stigma is twice as likely in military populations than in comparable civilian populations (Corrigan, 2004; Weeks et al., 2017, McGuffin, 2021) and is therefore recognised as a significant public health concern that cannot be overlooked (Link & Phelan, 2006; Hatzenbuehler et al., 2013; Frank et al., 2018).

Goffman (1963) provides a definition of stigma that encompasses its many facets:

> *‘An attribute that is deeply discrediting, that acts to reduce an individual from a whole and usual person to a tainted discounted one*’ (p265).

There is variation in the types of mental health stigma (Scambler & Hopkins, 1986; Reger et al., 2020); but all are believed to interact and contribute to the difficulties in military personnel seeking help (Coleman et al., 2017). Two prominent types of stigmas are reported upon; *‘public stigma’* and *felt stigma’* (Coleman et al., 2017, Reger et al., 2020; Fikretoglu et al., 2022). Terminology varies across the literature; however, the underlying definitions are synonymous. First, there is ‘*public stigma’* also known as ‘*enacted stigma’*; this involves the perceived act of discrimination, an endorsement of stereotypes against an individual with a stigmatizing condition (Frank et al., 2018; Reger et al., 2020; Fikretoglu et al., 2022). Previous studies on ‘*public stigma’* by Corrigan and Penn, (1999) and Couture and Penn, (2003) recognise three main themes about mental health issues and the societal beliefs that surround them. They are ‘*authoritarianism*’ whereby individuals with mental health issues are unreliable and irresponsible; *‘benevolence’* where individuals with mental health issues are viewed as naïve and incompetent and thirdly, ‘*fear and exclusion’* where they are perceived as dangerous and need to be isolated.

Should these stigmatizing beliefs become internalised by an individual, it can lead to self-stigma also known as '*felt-stigma'* and '*internal-stigma'* (Frank et al., 2018; Reger et al., 2020; Britt et al., 2020; Fikretoglu et al., 2022). Self-stigma implies that an individual feels shame and embarrassment towards their condition, it can lower self-esteem and give them a sense that they are not worthy of their working role, of receiving help (Mechanic et al., 1994; Frank et al., 2018). Multiple studies report self-stigma as a barrier to help seeking because of the concerns surrounding legitimacy of symptoms and their severity, along with the overriding need to follow the military ideology of '*soldiering on and not letting the team down*' (Keeling et al., 2017, p249). Indeed, Sharp et al. (2015) reported that self-stigma was a greater indicator for non- help seeking than public stigma.

As noted, stigma surrounding mental health is a significant issue in military contexts. It is purported by Acosta et al. (2014) that within the military context, mental health issues are labelled as different and undesirable. This negatively impacts on the individual and leads to lower self-esteem, increased negative mental health symptomology and poor help-seeking (McGuffin, 2021; Kaitz et al., 2022). In contrast, Forbes et al.'s (2013) UK study suggests that military personnel hold more positive attitudes in relation to the causes of mental health issues in comparison with the civilian population.

Recent research findings suggest that military leadership plays a significant role in military personnel's internalised stigma and help-seeking (McGuffin, 2021). Indeed, both negative and positive military leadership are associated with help-seeking attitudes and behaviours (McGuffin, 2021). Unsurprisingly, military personnel who experienced negative, destructive leadership held greater levels of internalised stigma and were less likely to seek help. The opposite was apparent for those experiencing positive leadership (McGuffin, 2021). A key component of stigma therefore is power (Link & Phelan, 2001), power through hierarchy (the organisation itself) or through groups (dominant military peers) combined with prejudiced beliefs ultimately, leads to discrimination, marginalisation and isolation (Britt, 2020). Multiple studies report that men, in general, display greater stigmatising attitudes about mental health issues than their female counterparts. This is especially evident in seeking help and impact on job rights, thus, highlighting a further area of gendered stigma towards mental health. Multiple studies suggest that this can be attributed to masculine ideals such as stoicism (Greene-Shortridge et al., 2007; Parcesepe & Cabassa, 2013; Forbes et al., 2013; Oliffe et al., 2016; Kaitz et al., 2022). Furthermore, Shields et al. (2017) suggest that together, gendered stigma and a diagnosis of a mental health issue present a central barrier to help-seeking; resulting in a '*code of silent stoicism*' and isolation in times of distress (p223).

Marriage in the military

The intention of this study was to be inclusive of any intimate partner whether they are married, co-habiting, boyfriend or girlfriend. However, within the military, marriage plays a significant role, so I was aware that I needed to explore this further in the literature before embarking on the research. McCone and O'Donnell, (2006) suggest that military life fosters incentives for military personnel to marry. The last 70 years has seen a constant decline in the proportion of people marrying in the UK (Thompson et al. 2012), but amongst military personnel, marriage rates are higher with 61.5%-62.1% in comparison to a 43% rate within the civilian population (Binnie, 2017). One reason is that being married entitles the serving partner to apply for Service Family Accommodation (SFA) enabling the spouse to move around with their serving partner to the different postings often required during a military career. In addition, Karney and Crown (2007) suggest that '*military marriages are distinct from civilian marriages'* (19) in those most personnel, whilst not the most vulnerable in society, often have lower attainment and socioeconomic status than their counterparts (Bachman et al., 2000; Segal and Segal, 2004). Blackwell and Litcher (2004) recognised that this was not only pertinent to the serving person but that both parties within the relationship held similar traits and vulnerabilities such lower attainment and socioeconomic status. They also suggest that unique attitudes pertaining to gender role exist whereby male dominance prevails, and the woman's role is to stay at home with the children. Historically, the roles in military work align closely to those traditional gender roles. More recently, Bachman et al. (2000) suggest that the military purposely select men with traditional views and women with non-traditional views of gender roles. As well as the distinctions made from withinside the marriage, there is also the outside circumstances arising from the demands of military service - such as long hours, involuntary separations, and potential exposure to danger which also sets apart the military marriage from a civilian one (Segal, 1989).

As a result of the many dimensions within a military marriage, studies suggest many military personnel are unmarried at point of sign up, but then subsequently marry more quickly and at a younger age in comparison to their civilian counterparts. Conversely, however, female service personnel tend to marry later and are older than their civilian counterparts (Adler-Baeder et al, 2005; Martin and McClure, 2000; Cadigan, 2000; Lundquist & Xu, 2014). The rationale for the disparity is uncertain (Military Family Research Institute, 2022). However, some reports have inferred a number of reasons for example the demands and challenges placed on service personnel make it difficult to balance marriage and service (Mutter et al., 2003); historically men and women have been treated differently by the military (Harrell et al., 2002) and being married and having children impinges on career advancement (Harrell et al., 2007).

Defining marriage is complex and there are several definitions currently in use (Steinmetz, 2013), causing uncertainty, since it can mean numerous things to different people (Keller & Keller, 2011; Nunberg, 2013; Green, 2015, Barriteau, 2016). For some, it is merely a legal contract with varying benefits attached depicting social status; for others, the binding of the couple together is for religious rites and for others, it is simply a cultural and social practice (Barriteau, 2016). Wolfson (2004) defines marriage as:

> '*a personal commitment and an important choice that belongs to couples in love. …It is a relationship between people who are, hopefully in love and an undertaking that most couples hope will endure. Marriage is also a social statement, pre-eminently describing and defining a person's relationships and place in society. …Marriage is also a relationship between a couple and the government. Couples need the government's participation to get into and out of a marriage*' (p4).

He further encapsulates marriage as:

> '*A specific relationship of love and dedication to another person. It is how we explain the families that are united because of that love. And it universally signifies a level of self-sacrifice and responsibility and a stage of life unlike any other*' (p3).

Theory, specifically Marital Paradigm Theory by Willoughby et al. (2015) and a further study by Willoughby et al. (2021) suggest that it is these generalised central beliefs about marriage that motivate individuals to either engage or disengage with the range of individual and relational behaviours required in a marriage such as commitment (Carroll et al., 2006; Willoughby et al., 2021), joint relational environments and couple concordance (Meyler et al., 2007).

In addition, Barriteau’s (2016) study used a combination of Bowlby’s (1969, 1982) Attachment Theory and Bronfenbrenner’s (1979, 2005) Bio-ecological Model of Human Development to explore how the bond is built between married individuals and how they adjust to their bio-ecological environments. Four themes emerged from Barriteau’s research: theme 1: *‘the freedom to be vulnerable with one’s spouse*,’ having the need to let down guards that may be present in other aspects of their lives; theme 2:‘*spiritual connection’* developing communication beyond words by sharing their joint life experiences with one another; theme 3: ‘*safety*’ derived from knowing that they had someone to care or advocate for them and theme 4: ‘*marriage as union’* merging two into one’ as a unique relationship unlike any other in their lives. The themes arising from these theories are noteworthy when considering marital life in the military. Very often, military families are displaced from extended family, this can be as a result of postings or from a lack of understanding about military life. As such, the distance from family that is experienced, can motivate relationship engagement and strengthen the bond between the couple (Scharp &Dorrance Hall, 2019).

For most in western society, marital life means two people living alongside each other, who love and are committed to each other, sharing experiences and engaging in joint ventures. The trajectory of the relationship is ascertained by the continuous evolvement of satisfaction by both parties over time. Cabrera and Aya (2014) suggest that to maintain the relationship, both parties are required to demonstrate desirable attitudes in their thoughts, feelings and behaviours; in other words, to ‘*be the best possible version of themselves’* (p6). However, when there is disruption to the equilibrium - such as an illness or a critical life event - it can threaten, alter, or transform marriage satisfaction. Consequently, any changes in the way that the couple functions will inevitably transform the relationship (Cabrera and Aya, 2014).

Within a military family, disruption and changes to couple functions are commonplace and occur more frequently (British Legion, 2021), especially for the spouse who chooses to travel with their serving partner (Lowe et al., 2012; Gray, 2022). Disruption to the equilibrium of a relationship can come in many guises but non so disruptive as in times of deployment; the disruption and changes are tenfold (Lemmon & Chartrand, 2009; Mansfield et al., 2010; Lowe et al., 2012). Logan’s (1987) study exploring U.S navy wives’ experiences of deployment recognised this and as a result, developed a model focused on the emotional cycle of deployment; comprising of seven distinct phases. It has since been modified to five stages by

U.S military psychiatrists (Pincus et al., 2001) who expanded its use across military family members of all services. The five stages align with separate time frames, each linked to one of the various military happenings: pre-deployment (notification to departure), deployment, reunion (preparation prior to return), post- deployment and re-unification both of which are linked to the time after return coupled with the associated unique emotional stressors (Esposito-Smythers et al., 2011). Indeed, Lowe et al. (2012) proport that for the family member left behind '*deployment can seem like an eternity*' which is experienced as an emotional series of peaks and troughs (p18).

Such additional responsibilities and move to independence are reported throughout the literature; in particular, by Lowe et al. (2012), Hawkins et al. (2018) and Long (2021) who recognised the undertaking of practical skills and building on them through multiple experiences of deployment increased the notion of independence and associated belief of being able to cope amongst the spouses. Despite this responsibility and independence, paradoxically Long's (2021) study found that for some of the spouses '*presenting an overly independent and 'smooth-running household to their returned serving partner could cause tension*' (p9).

Since the development and subsequent acceptance of the emotional deployment cycle, there has been a raft of literature specifically focusing on deployment, along with the practical and emotional adjustments made by all family members during that period (Esposito-Smythers et al., 2011; Lowe et al., 2012; Hawkins et al., 2018; Long, 2021). The emotional deployment cycle is now recognised and influences British military welfare provision (MOD, 2020a; Naval Families Federation, 2019; Walker et al., 2020).

Being a military wife

Many have theorised about the expectations of military spouses and the unpaid domestic labour they provide (Enloe, 1983, 2000; Jessup, 1996; Weinstein and White, 1997; Harrel, 2001; Gray, 2022). Harrel's (2001) historical analysis of gender and class-based role expectations, purports the engagement of volunteer actions by military wives to support the status position of their serving husband within military hierarchy. This is seen in the provision of *'free'* activities - such as attending ceremonial events, mentoring, and supporting younger wives and families, and entertaining guests (Jessup, 1986; Harrel, 2001). This unpaid labour is often unseen and made invisible by the very organisations that benefit from it. It is argued by feminist scholars that multiple armed forces rely greatly on the unpaid labour of civilian spouses to service personnel and that its invisibility aids the normalisation of military power (for example, Gray, 2022). Enloe (1983, 2000) suggested such unpaid labour is knowingly manipulated by the military to mould spouses into gendered roles such as providing childcare, support and caregiving whilst on and returning from deployment (Hyde, 2015; Gray, 2017). There are also potential differences in the unpaid labour provided by the spouse, dependant on their serving partners armed forces engagement status (regular or reservist), along with unit, rank, and role (Basham and Catignani, 2018). Indeed, Enloe (2000) and Long (2021) indicate that the military have become so effective in its control of unpaid labour, that it is now internalised and deemed the natural way to behave. As Gray's (2022) research with military wives found, the non-work or unpaid labour is widely acknowledged. Many of the participants described the non-work or unpaid labour of being a military wife as a '*a tough choice'* (p11). However, despite the hardship voiced, Gray's participants also spoke of being happy in the sacrifice undertaken, perceiving that their role was important to their serving partners' safety and wellbeing. Within these gendered roles, is a level of expectation which prevails, for which military spouses are often held accountable within the militarised culture; for example, a positive role model will perform unpaid labour, display militarised values of resilience and stoicism when supporting the serving partner (Harrison and Laliberte, 1993; Enloe, 2000; Gray, 2017; Cree, 2020). In contradiction, Gray (2017), illustrated that:

> ' . . . *several interview participants painted a picture of an insufficiently stoic, failed military wife -a figure who was widely seen as an object of scorn*.' (p233).

This suggests that when such ideals are not met, those spouses can be met with disdain from within the military community.

Such accountability to uphold the military expectation can lead to problems arising. It can mask deviant behaviour, such as violent abuse towards women. Harrison (2006) reported that because of harsh penalties placed on the serving person if identified as an abuser, it produces a culture of secrecy amongst lower ranks and within the military communities to ensure it is kept from the outside and the chain of command. Similarly, at times when the serving person is mentally unwell, it can diminish access to services in fear of repercussions, being labelled as '*problematic*' or '*in need'* or even negatively impact on the serving persons' career (Lowe et al., 2012).

3.5 Feminist vision, values and spirit

Just as I felt compelled to include whole stories so that participants' voices were at the forefront of my research, the relationship between the participants and myself also featured as a priority in my thinking. I wanted my participants to feel empowered and, as far as possible, to feel equal and the relationship be one reciprocity. I wished for us, where possible to be collaborators on this journey. Much of these sentiments align to feminist vision, values, and spirit (Merrill and West, 2014; Crotty, 2015). There is a lack of consensus in defining a single definition of feminism or feminist research (Crotty, 2015). Fonow and Cook (1991) suggested:

> '*that carefully designed research grounded in feminist theory and ethics is more useful to understanding women's experiences than an allegiance to any one particular method as more 'feminine' than another*' (p8)

Fundamentally, this is the standpoint in which I position myself; it is more about the collective essence of the various forms that feminism takes, rather than following one specific direction. I can relate to Kelly et al. (2013) who express the need to create useful knowledge, but in its creation, be able to '*make a difference',* allowing the knowledge gained to be used by others (p1). They state:

> '*Feminism for us is both a theory and practice, a framework which informs our lives. Its purpose is to understand women's oppression in order that we might end it. Our position as feminist researchers, therefore, is one in which we are part of the process of discovery and understanding and also responsible for attempting to create change*' (p1).

Within feminist research, it is suggested that the interview is of particular importance because of its capacity to empower (Beetham & Demetriades, 2007; Merrill and West, 2014). Indeed, the predominance of feminist research is that it is by women and for women (Merrill and West, 2014). Oakley (1992) argues this point by suggesting, women hold a shared identity with one another; they both sit *'inside'* the culture and therefore have experienced similar situations as a result (p59). Conflicting with this belief are other scholars, such as McKee and O'Brien (1983); Wise (1987), and Harding (1987). Harding (1987) who stated:

> ‘*Significant contributions to others’ emancipation movements have been made by thinkers who were not themselves members of the group to be emancipated*’ (p11).

Considering my research, the expectation was that women participants would predominate, and therefore be undertaken by a woman for women by giving a voice to their experiences; however, the research was open to both men and women so there was a possibility that not every interview would be as Oakley (1992) suggested and that indeed the words of Harding (1987) hold credence. However, an ‘insider’ element as Oakley (1992) proposed remained, since I am a military spouse and therefore share some cultural commonality with the participants, regardless of gender. Furthermore, feminist research, acknowledges the presence of the researcher throughout. Stanley and Wise (1993) stressed that:

> ‘*all research involves, as its basis, an interaction, a relationship, between researcher and researched …….. Because the basis of all research is a relationship, this necessarily involves the presence of the researcher as a person. Personhood cannot be left behind, cannot be left out of the research process….. We see the presence of researcher’s self as central in all research*’ (p161).

As Stanley and Wise (1993) suggested, the relationship is first and foremost the basis of the research. Feminist researchers push against the notions of interview detachment just for the sake of it, and strive to build democratic, more equal relationship (Merrill and West, 2014). This is to promote a more conversation like interaction, whereby the researcher is able to answer questions about their own life if asked. Such interaction aids with rapport building which is crucial when researching difficult and/or sensitive topics (Lee, 1999). A noteworthy point by Oakley (1981), indicated that rapport in a research context differs to the dictionary definition:

> ‘*the acceptance by the interviewee of the interviewer’s research goals and the interviewee’s active search to help the interviewer in providing the relevant information. The person who is interviewed has a passive role in adapting to the definition of the situation offered by the person doing the interviewing. The person doing the interviewing must actively and continually construct the ‘respondent’ (a telling name) as passive*’ (pg35).

Further, Oakley (1981) and Finch (1984) stated that it is of ethical importance that the interview style is founded on '*reciprocity*' and '*mutual self-revelation'* (Lee, 1999). Oakley (1992) proclaimed, '*no intimacy without reciprocity*' (p49).

However, caution needs to be applied; if reciprocity and self-revelation are deployed strategically, the interview can become a series of techniques separated from the ethical foundation they are based upon (Finch, 1984; Kollock & Blumstein, 1987; Lee, 1999). Brannen (1988) highlights two areas of power that can emerge within the interview. By determining the interview form and content, whereby the standardised interview format is not rigid, places an element of control with the interviewee over the interaction, allowing the interview space to exert a two-way process (Lee, 1999). The control element arises from the interrelation between the topic, interview method and respective status of interviewee and interviewer. The equivalence between the two is significant and can promote a more conversational interview. The other area of power is of the opposite, whereby the interviewer has the ability of power by virtue of the sensitive information that they hold about the interviewee post interview (Brannen, 1988; Finch, 1984). Likewise, the vulnerabilities of interviewees may arise as a collective when there is no control during the interpretation of the data. Indeed, Fletcher (2022) infers that feminist researchers should question the hierarchies and power balances in all aspects of the research study, from who is conducting it, how the data is collected and represented through to how it is disseminated. Consideration of the potential hierarchies and power balances within my study are reflected upon and followed up in chapter 4.

3.6 Chapter conclusion

This chapter has illustrated the conceptual thinking that has informed the direction of this study and the development of this thesis. The conceptual thinking was based on my experiential knowledge and understanding, the literature review findings and my research aim and objectives. Whilst the literature review aided in some identification of the elements within the conceptual framework, the exploration of my own experiential knowledge, understanding and values provided a clear direction in terms of methodology (discussed in chapter 4) as well as a lens with which to undertake data analysis (discussed in chapters 4, 5 and 6).

4 Chapter 4. Methodology and method

4.1 Chapter introduction

This chapter presents an overview of the methodology chosen for this study, how it connects to the research aims and objectives and the conceptual thinking described in previous chapters. It includes the justification for using a biographical approach and methods used to recruit and select participants and to gather the data. This is followed by an exploration of the data analysis framework adopted to interrogate the data. The key ethical issues of consent, protection and confidentiality are discussed, especially pertinent in biographical research where participants may potentially be more easily identified, ensuring participants were not harmed by taking part in this study. Finally, I reflect on my research journey up to this point and its emotional impact on me as a researcher.

4.2 Qualitative Interpretative Paradigm

Epistemological stance

Residing within the qualitative or interpretative paradigm, this study takes the epistemological stance derived from the idealist viewpoint, based on the innate complexities of individuals, and their ability to shape and construct their own experiences. Unlike the positivist paradigms whereby an objective approach uses systematic scientific tradition to measure and report experiences (Crotty, 1998), the interpretative position aims to capture the dynamic, holistic and personal aspects from the viewpoint of those experiencing them (Polit and Beck, 2014). As such, the idea of truth and meaning is not constructed solely on one reality but a fusion of realities as the individual connects with the social world (Crotty, 1998; Polit and Beck, 2014). Furthermore, Crotty (1998) lays claim that different interpretations can arise from the same experience. Indeed, Patton (2015) suggests that reality is relative and subjectively created with no absolutes.

To explore the experience of military spouses' during their UK serving partners' mental health issue, a qualitative, interpretative approach was deemed most appropriate. Central to the aims of the study and the conceptual thinking informing my study, a qualitative approach can provide insights into experiences, discomforts and needs as well as illustrating how care can be improved (Morse, 2000).

Ontological position

Also, for consideration, is the ontological position of the researcher (Annells, 1999). The experiences held by the researcher often shape and inform their view of the world and will inevitably influence the choice of research approach (Denzin and Lincoln, 2013). My experience of being female, a military wife, professionally as a nurse/health visitor and SHA, along with personal values and beliefs held, have shaped me and influenced my ontological stance. Indeed, some of this is evident in my conceptual thinking in chapter 3. Like Crotty, (1998) and Polit and Beck (2014), I am of the belief that multiple constructed realities exist, are determined by personal frames of reference, and are influenced by the connections made with the social world. I also hold the belief that all individuals should be afforded the opportunity to share their truth of a given experience.

In contrast to the positivist approach where objective, quantifiable and generalisable results are provided, this qualitative study intends to make available unique, in-depth, rich accounts of the experiences of living alongside UK serving personnel during a mental health issue. To achieve this, it is suggested that exploratory questions, which are broad and undefined are typically used (Holloway and Jefferson, 2000). As alluded to earlier, the assumptions made are that there is no one sole reality and that multiple interpretations arise from the same experience. Not only are interpretations made by the individuals themselves, but the interpretations made by the researcher must also be acknowledged. Alvesson and Skoldberg (2017) suggest that all references made to empirical data constitute '*results of interpretation'* (p9). Theory, therefore, is, emergent from data collection and analysis then built inductively as opposed to theory or hypothesis testing (deductive) (Polit and Beck, 2014). To this end, adopting a qualitative methodology for this study was deemed most appropriate.

4.3 Choosing a biographical approach

Under the umbrella '*qualitative research'* is a range of methodologies for exploring the lived experience and uncovering the nuances of everyday life (Polit and Beck, 2014). Likewise, there has been the emergence of multiple methods specifically concerned with researching lives under the umbrella of biographical approaches such as oral-histories, life stories, biographical research, personal histories, and auto-ethnographies (Merrill and West, 2014; Liamputtong, 2019) and the terms are often used interchangeably.

Narrative inquiry provides a focus on experience (Clandinin, 2006) and is defined by a three-dimensional space, the interaction between the personal and social stories of both participant and researcher; the temporal dimension which illustrates continuity; and finally, the place illustrative of a specific situation (Clandinin and Connelly, 2000). Whilst narrative inquiry offers a methodology to explore experience, is usually limited to particular stories, specific to defined situations or topics (Clandinin and Connelly, 2000). Biographical approaches investigate an individual's lived life story; referring to the events and social conditions that shape the different aspects of their lives (Plummer, 2006; Georgaca & Zissi, 2019). They illuminate the '*meaning'* of personal experiences (Carless and Douglas, 2016). Biographical approaches acknowledge that lives are socially constructed, built up of multiple threads such as family, work, education, all of which influence the present (Johnson, 1976; Clarke, 2000), but also how an individual's past is selectively constructed from the knowledge and understanding gained over time (Georgaca & Zissi, 2019). Biographical approaches move beyond the exploration of a specific snapshot in time, or a specific role allocated to the individual. They allow individuals to construct and reveal their unique, dynamic reality within their context, because of past experiences, future expectations and individual motivations. Biographical approaches shed light on an individual's past and current experiences, their understanding and their actions, which have shaped their perceptions, and life course trajectories (Stanley, 1992; Rosenthal, 2004; Carless and Douglas, 2016).

For this study, my aim, as highlighted in the beginning of this thesis, was to be fully focused on the participant; their story, their voice, their experience - from a starting point of their choice. Using a biographical approach provided a methodology which enabled me to step back from the stories and allow the participants the freedom to share their story without restriction of time or place. Adopting a biographical approach enabled me to uncover the idiosyncratic and collective aspects of living alongside a serving partner during their mental health issue. Biographical research posits an emphasis on the dynamic intricacies of an individual's life and enables individuals to relay their own stories as they perceive them (Rosenthal, 2004). A biographical approach is salient, as it places individual experiences (which are very often marginalised or silenced – as discussed in chapter 3) at the centre, with a focus on their subjective explanation (Plummer, 2006; Merrill and West 2014). In recent years, the use of biographical research, especially across sociology, psychology, education, health, and oral history disciplines has increased (Merrill and West, 2014; Liamputtong, 2019).

Biographical origins

In recent years, the use of biographical research, especially across sociology, psychology, education, health, and oral history disciplines has increased (Merrill and West, 2014; Liamputtong, 2019); however its origins are rooted in oral history dating back to the French Revolution (Merrill and West, 2014; Liamputtong, 2019). Post-World War 1 saw considerable movement in biographical research. Thomas and Znaniecki's book *The Polish Peasant in Europe and America* (originally published in 1918-1921) is deemed one of the earliest and most significant examples of biographical research (Merrill and West, 2014; Brannen, 2020; Bainbridge et al, 2021). Thomas and Znaniecki work alongside, the work of Park and Burgess in the 1920s further progressed biographical enquiry, through engagement with the real world and highlighting the advantages of capturing the participants' worldview of experiences. Both pieces of work were pivotal in the rise of the Chicago School of Sociology. (Merrill and West, 2014; Liamputtong, 2019; Brannen, 2020).

The subsequent decade saw Chicago School of Sociology movement grow with further fieldwork and studies among young criminals, the poor and immigrants in their own environment (Merrill & West, 2014). Alongside quantitative data, case studies were the preferred method to illustrate the lived experience. In the 1930's the movement saw the use of life histories. Plummer (2001) purports that the three publications; *The Jack Roller* (1930); *The Natural History of a Delinquent Career* (1931); and *Brothers in Crime* (1936) by Shaw, also unequivocally hold historical significance in the field of biographical research. Despite such key pieces of work, biographical approaches declined until a resurgence in the 1960's and 1970's.

The resurgence was partly due to the second feminist movement and feminist researchers alike in the late 1960's, especially across North America and the UK (Stanley, 1992; Chamberlayne et al., 2000; Merrill and West, 2014). The appropriateness of bibliographical approaches to redress the imbalance of the marginalised woman's voice had been recognised in studies such as McRobbie and Garber's (1976) girls and youth culture and Pollert's (1981) study of working-class women in a cigarette factory. Biographical approaches enabled women to be drawn:

> ‘*out of obscurity, repairs the historical record and provided an opportunity for the woman reader and writer to identify with the subject’* (Reinharz, 1992, p126).

Biographical approaches continued to keep pace, and scholars across a range of disciplines advocate biographical approaches and methods as a means of exploring how people live and experience everyday life (Bertaux, 1981; Chamberlayne et al., 2000; Plummer, 2006; Bainbridge, 2021). It is also suggested biographies are particularly useful in illustrating the subjective meaning of the experience in sensitive or intimate topics (Thomas & Znaniecki 1958. Bertaux, 1981; Plummer, 2006; Erel, 2007; Amini and McCormack, 2020).

Biographical approaches

Biographical approaches centre around the telling of auto/biographies (Stanley, 1992) and as such elicits stories not just from the present but also the past and future (Clarke, 2000). All of which are intertwined and transcend multiple theoretical and practical territories (Andrews, 2007).

Adopting a biographical research approach facilitates an understanding of patterns in people’s experiences but also identifies the uniqueness in lives; Merrill and West (2014) suggested the central question in biographical research is highlighting *‘the relationship between the particular and general, uniqueness and commonality*’ (p2).

Rosenthal’s (2004) definition goes further, suggesting that whilst biographical research is a ‘*social construct of social reality*’ it also includes the researcher’s active role:

> ‘*The main concern of biographical research is to understand social and psychological phenomena and to explain them in context of the process of their creation, reproduction and transformation*’ (p62).

Thus, suggestive that the positionality of the researcher is recognised (Rosenthal, 2004; Andrews, 2007; McLeod, 2011). Acknowledgment of the effect on the biographical content, posed by the interactional context and interpretative role of the researcher, in determining and presenting the findings is equally important (Georgaca & Zissi, 2019). McLeod (2011) purports that the very act of undertaking qualitative research is a *‘personal activity’*. The ‘*interactional context’* involves embarking on meaningful relationships with participants, whereas the ‘*interpretative role’* presents the personal struggle resulting from challenging assumptions to gain new understandings (p195). Biographical data does not simply reside within one discipline (e.g., sociology, psychology, education, health), it incorporates multiple interjects from across a range of disciplines. Andrews (2007) suggests that it is not the data that can be problematic, but it is academic inflexibility that resists the interdisciplinary nature of the biography itself. Indeed, there is continued debate on the struggles of how to represent participants, the status of stories, and the dominant discipline (Andrews, 2007; Merrill and West, 2014; Bainbridge et al.,2021).

As with all methodologies, it is also important to consider the limitations of biographical research. As discussed, the use of biographical approaches has taken pace in recent years and has resulted in the undertaking of a plethora of biographical studies across different topics and disciplines; for example, Zinn's (2005) study of health and illness; Barken's (2014) study of carer experience; Amini and McCormack's (2021) study of experiences of sex and sexuality; Georgaca & Zissi, (2019) and Macdonald's (2021) studies of mental health service users, Marincek and Rerat's (2021) study of sustainable transportation and, You and Lee's (2021) study of working life. However, this is not without detriment, since it has been noted that despite the emergence of more studies, there is continued scepticism regarding biographical approaches by some scholars (Bainbridge et al., 2021). And where biographical approaches have been executed, the overall quality in some studies has been deemed poor, due to the lack of exploration into the complexities of biographical approaches (Clandinin et al., 2007).

A further weakness can be the lack of clarity in terminology: biography, life course, and narrative. The synonymous terminology used across the field, has led to a blurring of the boundaries and multiple interpretations which cause confusion amongst early biographical researchers (Andrews, 2007; Merrill and West, 2014; Liamputtong, 2019;). Given the potential limitations of biographical approaches highlighted above, it was paramount that the biographical methodology for this study was explicit and focused. This is discussed later under data collection and also rigour (or trustworthiness) of the study (see section: quality measures in this research).

Despite the growth of biographical approaches across multiple topic areas and disciplines as highlighted earlier, the use of biographical approaches with serving personnel's' military spouse is scarce. Indeed, this is unsurprising, given the earlier recognition of the lack of studies in chapter 1 and 2. Preceding this study, those studies residing in the qualitative paradigm, relating to this study's topic area, for the most, have taken a phenomenological stance. They have aimed to understand the essence of a personalised experience by gathering a description of how people have received and processed a specific phenomenon (Chamberlayne et al., 2000), opposed to exploring the individual's life and the stories of their experiences. Considering the aim, objectives and conceptual thinking highlighted in the earlier chapters, a biographical approach was selected for this study, in order to place the voice of intimate partners and their stories at the heart of the research (West et al, 2007). Central to this study was the desire for the participant voice to be heard, therefore retaining the whole story was vital; as Pinnegar and Daynes (2007) argued '*the story is one of, if not the fundamental unit that accounts for human experience*' (p4). Equally, the literature review identified gaps: one in topic focus, specifically military spouse experiences. The other in methodology, whereby the rich in-depth, subjective experiences of living alongside a serving partner during a mental health issue could be voiced. To that end, a biographical methodology was adopted for this study.

4.4 The life story interview

The field of biographical research is not homogenous, rather it includes a range of methods at the researcher's disposal. They range from the unobtrusive such as simple observation, audio-visual records, self-recordings, written or pictorial documentation (Kellehear, 1993a) whereby no contact with participants is required, to contact methods such as face-to-face interviews. The latter twentieth century saw some uptake in unobtrusive methods in social sciences for example surrounding obstetrics (Hahn, 1987), women's health (Chrisler and Levy, 1990; Gartner and Stone, 1994), and HIV (Herzlich and Pierret, 1989; Persson and Newman, 2008). Documentation, observation, reference texts and articles all formed the basis for analysis. However, despite the advantages of unobtrusive methods such as safety, cost, and the non-disruptive, non- reactive nature, they remained controversial in the social sciences and lacked the possibility of studying individuals from their own perspective (Liamputtong, 2019). Indeed, within the social sciences, life or oral histories still dominate as Chamberlain (2006) posits:

> '*Documents may be imperfect renditions of the past, but to talk to a witness was to engage directly with the making of history, and we asked no more of a witness than that they narrate what they saw or experienced*' (p390).

Similarly, to the terms biographical/narrative approaches, multiple terms are used when referring to life or oral histories such as life story, life narratives, personal history (Atkinson, 2007). Whilst all are a central route for understanding human experience, subtle distinctions exist between them. Life histories impart an entire life narrated through memory with a greater emphasis on the past and without much interest towards the future (Hesse-Biber and Leavy, 2005; Liamputtong, 2019). Oral histories and life stories often emphasise specific parts of life (Bryman, 2008) and allows the individual to convey their voice and perspective, illuminating how their life is constructed and reconstructed (Atkinson, 2007). However, some academics, such as Titon (1980) go further and purport a distinction between life story and oral history:

> '*In oral history the balance of power between the informants and historian is in the historian's favour, for he asks questions, sorts through accounts for the relevant information and edits his way towards a coherent whole ……But in life story the balance tips the other way, to the storyteller, while the listener is sympathetic, and his responses are encouraging and nondirective*' (p283).

In the same vein, Liamputtong (2019), recommended that when embarking on life story interviews, it is imperative that respect towards the storyteller is strongly emphasised, and the storyteller is aware that the subjective meanings within the stories are pivotal to our sense of knowing. Fincher (2012) concurred by reinforcing the notion that the stories heard are *'true'* to the storyteller.

Carless and Douglas (2016) suggested that life story interviews facilitate the researcher to discover greater worlds from inside the personal world of the storyteller. At the core, the life story interview allows the storyteller:

> *'An opportunity to tell his or her story, the way he or she chooses to tell it so we can learn from their voice, their words and their subjective meaning of their experience of life'* (p233).

The strategy for telling stories typically includes plots, time sequences and characters (Plummer, 2006) and typically follows the journey through life, beginning with childhood into adulthood (Liamputtong, 2019). However, as Plummer (2006) indicated, the thread that holds the journey, plots and time sequences together is an '*underlying sense of motivation*' (p39). The '*motivational well'* is the point at which individuals explain who they are, the context, why they are as they are, and future aspiration. Such scene setting as Plummer (2006) explained has become a crucial element in constructing modern personal stories. While Plummer's (2006) experience pertained to sexual stories, he recognised the same '*motivational well'* in other scenarios. He surmised that the use of the '*motivational well'* has increased in life story interviews because it is recognised multiple, other plausible explanations are available (Plummer, 2006; Coulter and Smith, 2009). He recognised the importance of scene setting as a means of understanding other underlying motivational plots; the example Plummer (2006) used '*recovery tales'* arising from experiences of dysfunctional family experiences (p40).

The life story interview is specific in method, it requires time spent together between researcher and participant, to facilitate a collaborative process of storytelling and listening (Hesse-Biber and Leavy, 2005). At the heart of life story interviews, is the opportunity for the participant to tell their story in the way they choose. To that end, using a standardised closed question interview would not enhance the sharing and disclosure of their experiences and self-expression. The format for life story interviews, therefore, is predominantly unstructured or at most, semi-structured. The interview consists of an open request to tell their life story for example, '*tell me your story?'* and specific themes should be avoided (Rosenthal, 2004). Active listening is required on the part of the researcher; along with note making, especially in areas where the participant detail is brief. The notes can then be used to formulate '*internal narrative questions'* however they should not be posed until the later phase of the interview or at a second interview (Rosenthal, 2004, Zinn, 2005; Georgacca and Zissi, 2019; MacDonald, 2021). Both Rosenthal (2004) and Atkinson (2007) proposed undertaking more than one interview and leaving the duration of each interview solely with the storyteller, thus allowing the interview to run naturally and without interruption. Rosenthal (2004) named the first interview the '*biographical self-presentation'* since it is often the longest biographical narration (p50). Depending on how the storyteller chooses to share their story, inevitably has an impact on the length of the interview, typically ranging from one to two hours.

The later part of an interview or preferably second interviews have a valuable place in biographical research; opening the questioning period to pose any '*narrative-generating questions'* (Rosenthal, 2004; Liamputtong, 2019). Very often, one interview is inadequate to gain the depth required; a later interview allows further exploration and clarification of points made (Polkinghorne, 2005). This is not without caution; the later or second interview is semi-structured in nature. However, the questions should not interrogate opinions or reasons such as '*why did you do that?*', rather they should encourage the participant to expand on certain areas for example

'*Could you tell me more about…..?*' (Liamputtong, 2019). The semi-structured approach facilitates flexibility for the participant and researcher, since it allows both parties some influence over the direction of the interview, facilitating collaboration and co-construction of the story (Bold, 2012). Collaboration is paramount in biographical studies (Hesse-Biber and Leavy, 2005). Using internal narrative questions helps the participant to construct meaningful responses and for the researcher to address the topics under investigation (Liamputtong, 2019). The researcher's role is not only collecting the stories told, but to negotiate and be reciprocal, by offering what is needed to actively involve the participants in the process; for example, using photographs to initiate the storytelling or providing pen portraits or transcripts of the interview for review (Merrill and West, 2014).

Undertaking life story interviews is not without its challenges. They can be time consuming and require robust interpersonal and communication skills during the interview process. Before the interview begins, researchers need to be open, honest and describe in detail (section: informed consent), the research alongside being appreciative of the time given by the participants (Lee, 1999). During the interviews, active and careful listening is fundamental, all of which build trust and rapport with the participant (Carless and Douglas, 2016). A lack of rapport, openness and inattention from the researcher could lead to brief responses and a lack of data (Liamputtong, 2019). Sensitivity to the needs of participants, especially when working with vulnerable or marginalised participants is essential. For those who have traditionally been silenced, to then be given a voice can find it difficult to tell their story or in some scenarios may not possess the vocabulary to tell their story (Lee, 1999). The emotive nature of stories can be both challenging for the participant and the researcher alike (Lee, 1999). Reciting difficult periods of time or experiences can provoke emotional and sometimes physical responses. Such responses have an impact on the participant, so it is paramount that the researcher has considered potential harm and a strategy to address. Brannen (1988) argues that in situations where the participant is distressed, the interviewer's initial response may be to help. This however, such a response should be executed with caution, with underlying motives being considered. Brannen (1988) implies that the need to help is often '*more to do with helping the helper than those who are in need'* (p559). Indeed, Lee (1999) suggests that in such situations, the interviewer must '*undertake the difficult task of enduring and sharing the pain'* of the participant (p106). This is discussed later under the heading: protecting the welfare of those taking part. It follows that if the participant is distressed during the interview, it can also be stressful for the researcher (Lee, 1999). It is therefore imperative that researchers are supervised and have identified therapeutic support. This is discussed further under the heading: reflexivity work.

Life story interviews invariably produce large amounts of data to transcribe and analyse (Evans, 2004; Holloway and Freshwater, 2007; Merrill and West, 2014). This can become challenging and difficult to negotiate especially to early biographical researchers. Adopting a clear data management system and method of analysis can alleviate some of the challenges. Data management and data analysis will be addressed later in the chapter under the headings: transcribing and storing the data and data analysis sections.

Life stories have the potential for participants to lead and give them control over the direction of their story and its salient themes (Titon,1980; Elliott, 2005). To that end, life story interviews were used in this study. Whilst acknowledging the influence of military culture, yet by giving a sense of agency outside of the military confines, I hoped to facilitate the collection of a rich and in-depth account of the participants' experiences to promote greater understanding of the diverse, yet interrelated relationships, that ensue from those experiences (Andrews, 2007; Carless and Douglas, 2016).

4.5 The ethics of biographical research

All research requires ethical approval, to ensure that key ethical considerations underpinning the research study and researchers' behaviours/actions are explored. Behaving ethically goes beyond simply seeking approval (Clandinin, 2006; Merril and West, 2009), but involves '*thinking proactively about the values we bring to our work*' and doing more than '*simply avoiding harm'* (Merrill and West, 2014, p168). Biographical studies often deal with sensitive topics, some that may reveal injustice. The very nature of biographical study is that participants are asked to '*open up'* and tell their story which may include intimate and/or distressing accounts (Lee, 1999; Merrill and West, 2014). To that end, it is important to embark upon the research by adopting '*a considered ethical stance'*, ensuring a respectful participant encounter (Merrill and West, 2014, p168). The ethical considerations for this study are based upon the British Educational Research Association's (BERA) 2011 guidelines and from my professional and personal responsibilities as a Nursing and Midwifery Council (NMC, 2018) registrant of which one's ethical conduct is essential. Ethical approval for this research was granted by Northumbria University Ethics Committee (appendix 3).

Informed consent

One of the key ethical responsibilities in conducting research is informed consent (Merrill and West, 2014). To demonstrate a considered approach to informed consent in this study four components were utilised. The four central components namely disclosure, comprehension, competence and voluntariness are central to informed consent. As Franklin et al. (2012) suggest, these should be considered throughout the research process. Disclosure requires explicit information about the research is shared with participant. In this study, this was given in the form of a Participant Information Sheet' (appendix 4) which gave detail of the nature of the study and the process (BERA, 2011). This was sent along with an invitation letter to anyone who came forward during the recruitment phase and prior to any interviews. A further opportunity to verbally discuss any queries or concerns about the study was also available when organising the interview date and venue. Behi and Nolan (1995) support the additional use of a verbal conversation as well as written details to ensure the information is shared honestly and it is understood (also discussed under the heading: life story interview). Holding a conversation at this point, allowed me to review levels of participant comprehension prior to the interview. Competence refers to the capability of rational decision making. As a verbal conversation was held prior to the interviews, it opened the opportunity to ask questions enabling the participants to make a competent judgement as to whether to participate in the research or not. Finally, voluntariness, ensures the participants make a voluntary decision without cohesion of any kind. While this study provided no direct advantages to the participants themselves, they were advised that the findings may be used in military family policy. Similarly, they were advised that the research would be written as a doctoral thesis and for publication. However, it is noteworthy to highlight, the majority of participants stated that they felt by taking part they were helping others in similar situations. In this study, both the Participant Information Sheet (appendix 4) and the Debrief sheet (appendix 5) highlighted the right to withdraw without any consequence to them. One participant recruited via snowballing withdrew, following receipt of the invitation letter (appendix 6) and the participation information sheet (appendix 4). The assessment of participant willingness and voluntariness were ongoing; demonstrated by them attending and signing the consent forms prior to both interviews (NMC, 2018) (appendix 7). Obtaining the consent forms as evidence is deemed a requirement; however, there some researchers such as Fine et al., (2003) who highlight the contradictory nature of gaining consent. They suggest it reinforces differences in power, reminds the researcher of their *'accountability'* and '*strips them of the illusion of friendship and reciprocity'* with the participant (p178).

Protecting the welfare of those taking part

As alluded to earlier (section: ethics in biographical research), the notion of not causing harm to the participant is paramount. It is widely accepted that there are four fundamental ethical principles that underpin all human subject research; beneficence (to protect, defend and prevent harm to others), non-maleficence (not to cause harm), autonomy (have power to make rational and moral choices) and justice (to be fair, equitable and appropriate) (Beauchamp and Childress, 2001). Due to the sensitive nature of the research topic, it was anticipated that there might be occasion where the telling of stories might invoke intense emotional responses. To that end, I ensured that all the interviews were at a venue and at a time chosen by the participant, one which was private but where they felt relaxed and comfortable. While some participants, displayed emotion during their story telling (eyes welled up or a tear was shed), the emotional response appeared not to be severe in nature and had no lasting adverse impacts. Prior to the beginning of the interview, participants were reminded and reassured that they could stop or discontinue the interview at any point. Where emotions were visible during the interview, a natural pause followed, initiated by the participant. On one occasion, a participant reached for a tissue, they became tearful towards the end of their first interview, whilst talking about how exhausted they felt (for an example, see Christina's interview in chapter 5). At this point, we both took a moment, after a brief pause, and without prompt, the participant continued to tell their story (section: life story interviews). Even though the severity of emotion was minimal, I had prepared and shared at the end of the interviews, a support document (appendix 8), identifying key agencies available for referral and support (Merrill and West, 2014).

A further consideration during the recruitment, and the interview process, specifically surrounded the two participants who were students at the university. While I do not think at any point the students felt compelled to take part as their involvement was voluntary, I did provide additional reassurance. One participant (Christina) had been a been a member of my personal tutor group. During her studies I had been aware she was a military spouse, however due to the professional relationship held between us, we had never shared personal stories with each other, and I was unaware of her situation. During my recruitment drive, Christina was coming to the end of her studies, I had asked if she would share my promotional postcard (appendix 9) within her military spouse networks. It was at this point, she came forward. At the time of interview, Christina had completed her studies and was no longer a student within the university. Sara, the other student from the university was in her last her last year of study. Sara volunteered after hearing about my research from another academic. At the point of recruitment, and after the interview, I had no academic input during her studies. My only contact was during the interviews; however, I did give added reassurance, in that, her taking part or discontinuing in my research would in no way have implications for her study.

Confidentiality

Confidentiality as a principal can be viewed from two aspects, one aligned with data storage and how the researcher safeguards personal information (section: transcribing and storing the data) and the other surrounds the use of the data once collected in protecting identity (Merrill and West, 2014). As suggested earlier, biographical research very often involves the sharing of intimate and/or distressing stories and as such, building and maintaining trust is the corner stone when handling a participant's story (Merrill and West, 2014). Indeed, using a pseudonym can ensure confidentiality and privacy to some degree. In an effort to include the participants as collaborators in co-production of the findings, all the participants were asked if they had a preferred pseudonym. Only two participants (Christina and Lauren) expressed a wish to choose their own, the others shared no desire to choose one and left the decision up to me. Likewise, removing or changing location names can also support confidentiality. Again, during the telling of stories, multiple locations where included. Following discussion with both the participants and my supervisors, it was felt unnecessary to change the location name of various deployments such as Afghanistan, Sierra Leone. However, when the locations involved specific army camps, or towns I replaced these with pseudonyms to reduce possible identification by association.

Due to the nature of biographical research, the material is often in-depth and of thick description (Merrill and West, 2014). As well as participant and location names, it may be as difficult to disguise certain situations or events that are possibly known to others outside of the research team and participant (for example, a situation/event that was high profile and drew a lot of attention due to its nature). This is known as deductive disclosure (Lee, 1999). In this study, most of the participants' stories were able to be anonymised; however, two participant's story and the situations/events within it, meant deductive disclosure would have made the participant and their family easily recognisable. As Merrill and West (2014) suggested, such scenarios need to be highlighted, and discussed, so that confidentiality and privacy can be maintained. In both cases, the participants and I saw the difficulties. For one of the participants, the difficulty was realised when reading the pen portrait at the beginning of interview two, they stated: *'It's going to be difficult for you to anonymise us in this'.* That comment triggered a discussion prior to the second interview. Reassurance of confidentiality was given to both participants, and it was agreed that I would omit from the findings, the specific situations/events that would risk exposing either the participant or their serving partners' identities. Omitting such detail lessened the impact of their story; however, maintaining confidentiality and privacy were paramount as per my personal ethical stance as well as abiding by NMC (2018) and BERA (2011) guidance.

4.6 Participant recruitment and selection

This study adopted a purposive strategy, underpinned by the belief that the researcher's knowledge of the given population is important, to enable strategic selection of participants who will best contribute to the study (Polit & Beck, 2014). It is essential to recruit the right participants for the study, so that those selected are best placed to answer the research question (Silverman, 2017). Providing detail about how the participants have been selected is necessary for quality and transparency within the study (Gobo, 2006).

The recruited participants in this study were able to offer valuable insight into the specific experience of living alongside their UK serving partner with a mental health issue from their own perspective. From my preliminary discussions with the wider military service community prior to participant recruitment, it was apparent that there was a display of protectiveness. Yambo et al.'s (2015) US study described '*obedience duty'*, whereby the serving member obeys military authority figures, and their family follows them in doing so, making it an important and strictly followed, military custom. Some studies have found this custom problematic when trying to recruit partners of veterans or serving personnel via contact with the veteran/serving personnel (Yambo et al., 2015). It would have been naïve for me to think that such customs would not be applicable to UK military families and, as such '*obedience duty'*, as a challenge to recruitment was worth consideration. Other scholars found that recruiting through the individual receiving treatment removed the partner's independent, autonomous decision to participate (Smith, 2006. Franciskovic et al., 2007. O'Toole et al., 2010). I wanted the participants in this study to take part without any influence imposed from any aspect of the organisation, so I decided to recruit participants outside the MOD structure.

Given that I envisaged that there would be challenges with recruitment for the reasons stated above, the aim was to simply recruit as many participants as possible, who fulfilled the criteria consistent with the research question (Silverman, 2017). As discussed in chapter 1 for this study, the criteria were:

- participants were the military spouse (inclusive of wife, girlfriend, husband, boyfriend, partner) of serving personnel of any rank across the tri-services, Army, Navy or RAF

and

- their serving partner had at some point during their serving career experienced a mental health issue; namely, common mental health disorders (depression, anxiety), adjustment disorder, or post-traumatic stress disorder.

I adopted two methods within my recruitment strategy; first, I used a '*non-invasive sampling strategy*' where I shared posters and postcards (appendix 9) to raise awareness of my research (Campbell, 2002, p2). As a military wife, I was able to use the wives and partners' networks to distribute materials such as leaving materials with community development workers specifically working with families alongside military welfare officers and military wives' choirs. I recruited five participants from local networking and responses to the posters. I also responded to a call out from the Army Families Federation who were writing a piece on army family experiences with mental health. They published my story and highlighted the research (appendix 10). While I did not recruit any participants from the article, I did receive an email offer to send recruitment materials for sharing in other areas (appendix 11).

I also recruited using a purposive snowballing process or word of mouth. Snowballing as a recruitment method has had widespread use, particularly when researching deviant, vulnerable or hard to reach populations (Atkinson and Flint, 2001; Polit and Beck, 2014; Liamputtong, 2019). It involves recruiting from referrals made by participants rather than formal routes, such as lists, data bases or screening (Liamputtong, 2019). It can be a quicker and more cost-effective way of identifying other participants, however by only recruiting from referrals there is the potential to restrict the sample to a small network or population (Polit and Beck, 2014). A further concern arising from snowballing is the lack of co-operation from those who have been referred, this can be affected by those who have taken part in the study for example did they trust the researcher, and did they really want to be part of the study (Polit and Beck, 2014; Merrill and West, 2014). Snowballing as a recruitment method has had widespread use, particularly when researching vulnerable or hard to reach populations (Atkinson and Flint, 2001; Liamputtong, 2019). I was able to recruit five participants this way. One advantage to using snowballing as a method meant I was able to recruit one participant who was particularly hesitant and wary of taking part. After reassurance and encouragement from her friend, she eventually came forward. Conversely, I also had one participant, who after being referred by a participant, declined to take part. No reason was given, they simply decided not to respond, once they had received the research information. By adopting purposive snowballing, I was able to recruit nationally, because of the transient nature of army life and military communities, it had meant that some of the participants had met friends when moving around with their serving partners. The moves inevitably relocated them across the country (chapter 3 and 5); however, bonds were maintained, and they had kept in touch.

At the outset of the study, I had no absolute number of participants in mind to recruit. Identifying an appropriate number of participants for a qualitative study is ambiguous, with some researchers suggesting there is no set sample size for qualitative research (Liamputtong, 2019). Others are more specific and indicate a sample of size between five and 25 (Cousin, 2009; Bagnasco et al., 2014). Goodson & Sikes (2001) argue that ‘large samples are unnecessary and even inappropriate’ (p75). It is important to go in-depth ‘*rather than wide’* with multiple participants (Cousin, 2009, p99). Qualitative approaches very often generate considerable amounts of rich data (Holloway and Freshwater, 2007); even the stories from a small number of participants, who share experiences with similar structural and social conditions can give enormous power (Seidman, 2013, p59).

Synonymous with the ambiguity surrounding sample size in qualitative research, is biographical research. The range is vast with Rosenthal’s (1995) study, whereby she interviewed 810 holocaust witnesses to the seminal work of Steedman (1986) who concentrated on two people, a mother and daughter. Despite the range, the predisposition amongst most biographical scholars is towards lower sample sizes (Morse, 1994; Evans, 2004; Merrill and West, 2014) ranging from two to 37 (Steedman, 1986; Holloway and Jefferson, 2007, respectively). Evans (2004) debates the in-depth nature of the interviews (section: biographical approaches and life story interviews) by suggesting that the sheer volume of data, can make large number unmanageable. A further point for consideration is not simply the number of participants but also the number of interviews carried out with each participant. As discussed under the heading: life story interviews, the method employed can involve more than one interview. In some biographical studies where there is only one interview per participant, the sample size spills into double figures, for example, Holloway and Jefferson (2007) with 37 participants, Georgaca & Zissi, (2019) with 27 participants; Amini and McCormack (2020) with 30 participants and Macdonald (2021) study with 16 participants. In contrast, other biographical studies such as Barken (2014) study, carried out only eight interviews following group observations and seminal work by Steedman (1986) involved two participants: a mother and daughter. Indeed, Morse (1994) purports that biographical research should *include* no more than six participants. The topic area and the population group are also deserving of consideration. While many of the qualitative studies surrounding military spouse of serving /veteran personnel did not use a biographical approach, considering the sample size in the specific topic area can also provide some insight into the uptake. For the most, the sample size was 10 participants or less (Sherman et al., 2008; Woods, 2010; Temple et al., 2017; Murphy et al., 2018; Waddell et al., 2020; Johnstone and Cogan, 2021). Only a few studies went beyond 20 (Verbosky and Ryan, 1988; Thandi et al., 2016; Brickell et al., 2021). For this research, nine participants were recruited, all of whom met the criteria and were subsequently selected.

4.7 The interview space

The interviews were arranged via telephone and the venue was chosen by the participant, allowing them to decide where they would feel most at ease (Finch, 1984). All interviews were carried out face-to-face, with some participants deciding to be interviewed at home and some on the university campus. The Participant Information sheet (appendix 4) was sent either by post or email ahead of the first interview, consent forms were completed prior to the commencement of each interview (appendix 7).

For the most, the starting point of any biographical research is to engage participants either through sharing stories or joining alongside the participants as they live out their stories (Clandinin, 2006). Whilst I shared some commonality as a military spouse, for this study, the participants were unknown to me, so the stories were initiated following an opening conversation about the interview (Clandinin and Huber, 2010). The data in this research was collected via two separate interviews. As suggested by Wengraf's (2006) work on the biographic narrative interpretive method (BNIM), the first interview was led by the participants and was initiated from a broad, single narrative question: *'Tell me your story?*'. Offering one opening question allowed the participant to take as much time as they wanted to talk about their experience without interruption or further questioning from myself. As discussed further in this chapter under the heading life story interviews, Rosenthal (2004) names this '*biographical self-presentation*'. The response to the question, was interpreted by all participants in a way, as an opportunity to offload their story, which for most, had a predominant focus on their serving partner. Like Plummer's (2006) '*motivational well'* (see below, life story interviews), in this study, the story of them and their serving partner together allowed context setting. The starting point of their story was left entirely up to the participant and the option of a prompt such as photograph was used to help those who found it hard to start (see below, life story interviews). Participants were encouraged to talk freely and without any prompts other than the photos they had chosen to share, reiterating their sense of agency within the process.

Closure of the interview is an essential stage which should not be overlooked (Merrill and West, 2014). Picking up on participant cues such as saying less, can be an indication they are coming to the end of their story (Wengraf, 2001). Conversely, the closure of the stories can be more explicit whereby the participant states '*I think that's about it'* (Wengraf, 2001; Riessman, 2013). During the first interview, so as not to pre-empt the story end, I tried to pick up on cues and they varied across the interviews. In most interviews, a natural end without any closing sentence occurred; the conversations naturally switched to other experiences such as deployment and generalised military life. In others, conversation was interrupted; for example, Lindy's doorbell started ringing and Lauren's children woke up which changed the direction of the story. At the end of the interview, participants were invited to ask me any questions regarding next steps or any other information regarding the interview process. Given the sensitive nature of topic, I anticipated that there was potential for distress during or post interview. To address this, as well as explaining the debrief document (see appendix 5), before leaving I had also shared the support document (appendix 8), identifying key agencies available for referral and support (Merrill and West, 2014).

As recommended by Wengraf (2006), notes based on what was said, were taken during the participants' story and subsequently used to inform the second interview. The second interview whilst more conversational in nature, was focused around four '*narrative generated questions'* (Rosenthal, 2004), which afforded me the focus specific to my research area (Mishler, 1986; Holloway and Jefferson, 2000); namely: the participants experiences thoughts and feelings. The structure of the interview allowed for follow up and greater in-depth participant self-reflection of specific points in time, such as during and after the treatment of their serving partners' mental health issue (Andrews, et al., 2008; Goodson 2013). The open-ended questions were used to ensure that the focus was brought back to their experience and that the research question was explored (Mishler, 1986). All the participants agreed to a second interview and dates were agreed prior to leaving. I also made a further follow up telephone call, prior to the date arranged to check that each participant felt happy to continue and confirm the agreed interview date. As discussed earlier, the second interview posed an opportunity for clarity and detail (Rosenthal, 2004). In preparation for the second interview, I asked participants if they could think about themselves, about their thoughts and feelings during the episodes that they had talked about. The length of time between the interviews varied; for most, it was one to two weeks, but for two participants the length between the two interviews was two days. This was due to logistical reasons, namely the travel distance between the participant and me.

Opportunities for the participants to revisit what they had said, occurred concurrently throughout both interviews by seeking clarification and summarising points made (Doyle, 2007). After leaving the first interview, I wrote a pen portrait (discussed below under the heading life story interviews) of the interview (appendix 12). This was written up to share prior to commencing the second interview, I did this as a means of seeking confirmation of what I had heard, was what they were trying to tell me (Polkinghorne, 2005). While I felt this was important to check that I had interpreted the stories as they had wanted, I did approach it with some caution. McConnell-Henry et al. (2011) makes a noteworthy point; namely, that by asking participants to review what has been said, could lead to distress or regret, especially when the stories are of a sensitive nature. Acknowledging this, I sought consent with each participant to share a pen portrait. For the most, participants said that they felt the pen portrait represented them; however, one participant (Lindy) highlighted one inaccuracy where my interpretation of what she said was incorrect. I had misinterpreted a line where Lindy was describing her serving partners view of Lindy's asthma, I had interpretated and recorded it as Lindy opinion, *'I have been ill at times, got quite serious asthma, but I'm never ill enough for him to come home'*; but she had meant it to be an example of her husband's opinion in that he feels she is never ill enough and therefore not a reason to come home. During the second interview, clarification was sought throughout; for example, by summarising the participant's responses to each question. As discussed earlier, the focus of the second interview was directed at participants' experiences during specific times so the immediacy of clarification during this interview was pertinent. Revisiting participants' accounts during the interview process, facilitates the opportunity for feedback, clarification surrounding the interpretation of the data, and review of the research questions (Stein-Parbury, 2009; McConnell-Henry et al., 2011). Similar to the first interview, I took cues from the participants as to when they had finished their response to each question. To close the interview, participants were invited to ask me any questions regarding next steps or any other information regarding the interview process.

4.8 Transcribing and storing the data

The interviews were fully transcribed verbatim with the notes taken during the interview, positioned alongside the text (Birt et al., 2016). Transcribing the stories, myself, whilst time consuming, was invaluable. It became a foundation from which the analysis was built. As recommended by Wengraf (2001), the time spent on transcribing allowed me to familiarise myself with the data and begin to reflect on the stories that had been shared and how they were told, as well as noticing their similarities and differences. Two interviews were carried out with each participant, equating to eighteen interviews in total. Across the two interviews, the times varied, the duration of the first interview was longer than the second one. The first interview varied from lasting forty-five minutes to two hours and the second interview lasted from twenty to forty-five minutes. The data generated averaged 4,352 words in the first interview, whereas the average word count for the second interview was 3,058.

Storage of all data pertaining to the participants must comply with the Data Protection Act (1988) and the General Data Protection Regulation (2018). All electronic data such as the recordings from the interviews and NVivo™ were stored on a password protected University computer. Dictaphone interview recordings were deleted from the device immediately once they had been uploaded onto the university computer. All paper data, including the typed-up transcripts from the interviews and participant consent forms were kept in locked storage at the university campus. Participants were informed that some data may be retained for longer than the duration of the study but only if required for publication (See appendix 4 and 5).

4.9 Data analysis

All story or narrative data necessitates some method of interpretation in order to explain how meanings, their associations and perspectives, are actively constructed throughout the interview. It requires the deconstruction of the participants' talk to illustrate to the reader the *'hows'* or the '*whats*' of the narrative frames of experiences (Holstein and Gubrium, 1995, p79–80). The origins of narrative analysis are primarily routed in literary theory with links to media and cultural studies. However, the last 50 years has witnessed a growing interest amongst social scientists who view it as a means to gain a deeper understanding of the social world (Geertz 1973; Bruner, 1986; Denzin, 1989; Riessman,1993).

There is a myriad of approaches congruent to analysing story or narrative data, the process of analysis can be challenging and complicated. Mischler (1995) and later Elliott (2005), recognised that to manage the multiplicity of techniques, a set of categories or typologies was required. Riessman (2008) outlined several classifications which included performative, structural, interactional, thematic and holistic analysis. Whatever the method selected, the overall aim of narrative analysis is the attempt to examine how people make sense of their lives through the stories they construct and tell (Earthy and Cronin, 2008). It is about how events are chosen, coordinated, linked and evaluated so that they are meaningful for a particular audience (Holloway and Freshwater, 2007).

Further, the analysis of stories is dependent on the researcher's stance; where their interests lie, the motivation for undertaking biographical research and the rationale of method choice (Lieblich et al., 1998). It is an iterative and intuitive process which involves '*analysing, collecting data, synthesis, reanalysing and so on*' (Bold, 2012, p121); therefore, suggesting that analysis does not only occur once data has been collected but commences during the interview and transcription process.

I also acknowledge, that data analysis was influenced by my own interpretations, experiences and the theories underpinning the study (Clandinin & Connelly, 2000; Fine, 2002; Riessman, 2008). Indeed, Fine (2002) suggested that even

> '*Giving voice involves carving out unacknowledged pieces of narrative evidence that we select, edit, and deploy to border our arguments*' (p218).

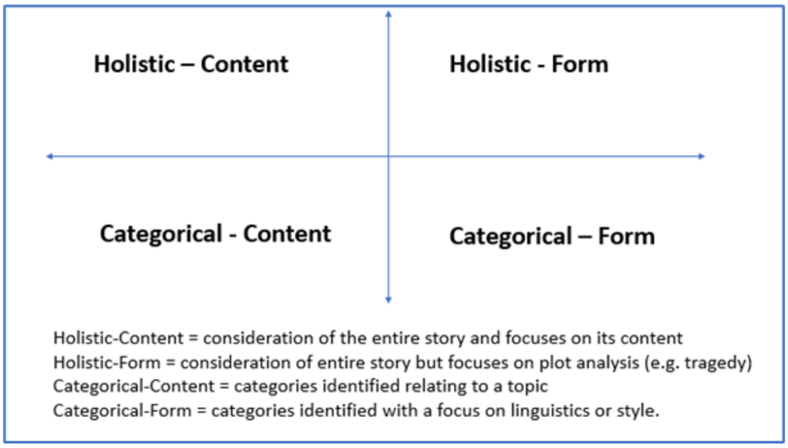
It is, however, of equal importance not to lose the uniqueness of each individual participant in their particular situation (Lieblich et al., 1998). It was important to present the stories in the participants' own words, not only to reduce misinterpretation and avoid fragmentation (West et al., 2007), but also to provide the context of their individual stories, facilitate understanding of the meaning behind them and to maintain the impact of their experience (Seidman, 2013, p19). However, several scholars have laid claim that since the narratives are subject to interpretation, analysis and are reproduced by the researcher, the act of editing may fundamentally reconstitute the sought experience (Cotterill and Letherby, 1993; Merrill and West, 2014). Despite such claims, Freeman and Kantz (1980) argue that this does not prevent a '*faithful portrait of the narrator'*. Researcher involvement needs to be explicit from the collection of data through to the production of findings (Bold, 2012; Merrill and West, 2014). Criticisms of the biographical approaches suggest that historically, there was minimal description of the researcher's involvement, with the relationship between researcher and narrator being relatively unknown (Dollard, 1933; Allport, 1942; Kluckholn, 1945; Langness, 1965; Blumer, 1969; Freeman and Kantz, 1980). As such, being explicit about the process of interpretation is fundamental for readers understanding of *whose story is being told?* Adopting a narrative analysis framework such as Lieblich et al.'s (1998) (see below, heading: analysing that data using a framework), illustrates how the processes of analysis were executed and how the stories were created.

Given the subject matter and the aims of the research, I highlighted the importance of considering the stories as a whole, prior to extrapolating themes or categories from within and across the stories. Whilst wishing to represent the participants as individuals to avoid dissecting them '*into thematic categories*' (Riessman, 2008, p12), I also recognised the value of identifying themes or categories to highlight the '*social and cultural character of personal narratives'* from which more transferable conclusions could be drawn (Andrews, 2013, p65). To that end, the application of differing analytical approaches was required. While open to several possibilities of interpretation, analytical pluralism as suggested by Clarke et al., (2015) facilitates a greater production of rich, complex and diverse understanding of the phenomena.

Analysing the data using a framework

Lieblich et al.'s (1998) work offers a framework for analytical pluralism since it encompasses both the completeness of the story and the generation of themes or categories. The framework categorises narrative analysis along two independent dimensions: '*holistic versus categorical approaches*' and '*content versus form*' (p12). Within '*holistic*' analysis, each individual story is considered as a whole and the parts within it, interpreted in context to other sections of the story. In contrast, the *'categorical'* analysis is primarily focused on abstracting phenomenon or themes from the individual stories but that are also shared across a group of people. The '*Content- Form'* continuum refers to the literary reading of the texts with *'content'* focusing on what happened, why it occurred and the roles of others within the story and *'form'* focusing on how the story is structured. As a result, the framework provides four possible avenues for data analysis (see table 5 below).

Table 5: Classification of narrative analysis. Lieblich et al. (1998), p.13-17.



Holistic-Content = consideration of the entire story and focuses on its content
Holistic-Form = consideration of entire story but focuses on plot analysis (e.g. tragedy)
Categorical-Content = categories identified relating to a topic
Categorical-Form = categories identified with a focus on linguistics or style.

In recent years, there has been a number of researchers who have used a *'holistic'* approach to their analysis. Beal's (2013) '*holistic-content'* analysis of stories created written accounts of nine women's stories about the onset of ischemic stroke. Her approach to analysis included temporally arranging the events and actions of each woman's experiences and then interpretating the consequences of their actions and how they contributed to the end point of the story. Draucker & Martsolf (2010) used '*holistic-form'* analysis to identify the overarching story types and plot lines between positive and negative dimensions of well-being in their study of adults who had experienced sexual violence. Riessman (1993) provided a description of '*content-form'* analysis, detailing how she segregated the text relating to '*divorce talk'* to highlight the differences between women and men's stories. More accustomed in the field of qualitative research, is that of content analysis whereby thematic clusters around recurring content are extrapolated from the stories given. This is indicative of the '*categorical-content'* quadrant within Lieblich et al.'s (1998) framework.

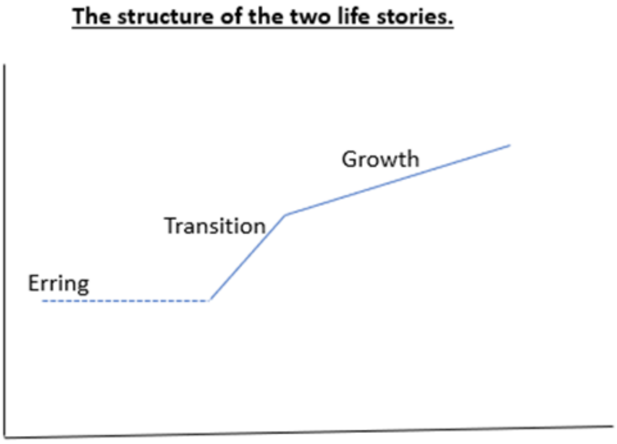
Whilst four single approaches to narrative data analysis are evident, Lieblich et al. (1998) identified that data analysis need not fit into one approach only. Using more than one analytical approach allows different perspectives to emerge from the stories (Holloway & Freshwater, 2007; Clarke et al., 2015). The focus of my study was on individual experiences and Lieblich et al.'s (1998) approach is consistent with the research aim. By utilising parts of the framework, the data gathered during this study is presented to include both the participant's whole story and the emerging categories. To this end, a combination of '*Holistic-Form'* and *'Holistic-Content'* analysis was used for each story as a whole. '*Categorical-Content'* analysis was used to emphasize the interactions between the insights from the individual stories and the categories emerging collectively.

Holistic-Form analysis

There are two strategies to consider in holistic-form analysis: structure analysis and two-stage life story analysis (Lieblich et al., 1998). Structure analysis considers the progression of the story whereby the plot develops over time and narrative typology, exploring the four principal narrative types of comedy, romance, tragedy and satire. Finally, there is the cohesiveness of the narrative, whereby the story is constructed to include a defined objective, the succession events leading to the objective - along with the relationship between the sequence and causality of those events.

In contrast, two-stage life story analysis demonstrates a different type of analysis to structure analysis since it is '*dominated by a single idea, which then provides an anchor for restructuring the teller's memories*', (Lieblich et al., 1998, p106). The two-stage life story analysis approach was developed as a result of life stories collected for Lieblich et al.'s (1998) study where interviewees were asked to share their life story using an outline to separate their lives into five to seven chronological chapters. Two interviewees presented their life stories in two stages and resisted requests to further subdivide, stating the two stages truly represented their lives. Lieblich et al. (1998) concluded that the participants' structure of their stories reflected the personality of the individual participant and their journey to finding '*self-actualisation'*. On application of the two-stage life story analysis, it did indeed reveal three distinct stages: a '*before and after a major life change'* with a shorter mediating '*stage of transition*' as seen in Lieblich et al.'s (1998) illustration below in figure 3 (p106).

Figure 3: The two-stage life story structure

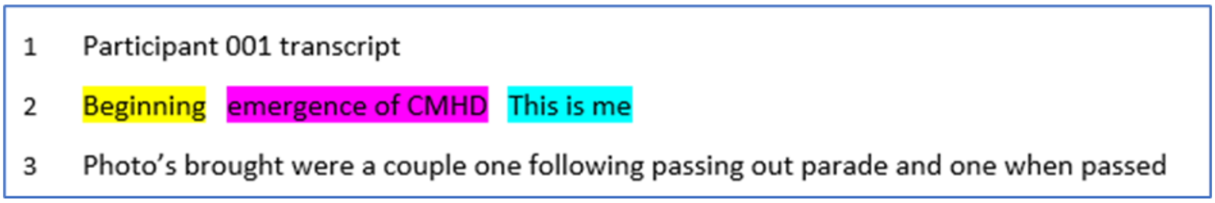


Participants recalled the beginning stage as the long, undifferentiated period with many years and events collapsed into one. In contrast, the middle stage was the active, transitional point which was described in more detail. The final stage was the present point of actualisation.

My study explored the experiences of military spouses living alongside their serving partner's mental health issue and therefore was specific to a particular period and a specific focus. Unlike the majority of Lieblich et al.'s work whereby whole life stories from earliest memory were gathered, my interviews did not stipulate a specific starting point. The starting point was left up to the participant to decide; they were simply asked '*tell me your story'*. For most participants, the stories began when they met their partners. The close similarity of the stories collected for my study to the two interviewees from Lieblich et al. (1995)'s study where two-stage life story analysis was implemented, was noteworthy. Whilst the topic of Lieblich et al.'s study was culturally and thematically different to this study, the three stages of the two-stage life story analysis approach were reflected within my participants' stories. In practice, when asked to tell me their stories, all participants proceeded to tell a conjoined story about themselves and their serving partner. Similarly, during each participant's first interview, the whole story of their relationship was shared. It was as if asking the question '*tell me your story'* opened a release lever; it appeared that participants needed to offload the whole story to me to provide a context or rationale for their situation. On analysis, the participants themselves were not always easy to locate in the story; the emphasis was very much focused on telling their serving partner's story.

Initially, what was generated from the interviews was a collection of years and events which set the scene about their relationship. Similar, to Lieblich et al.'s (1995) findings these events were collapsed into one and therefore were indicative of the **beginning stage** and named as such. As in Lieblich et al.'s (1995) study, the second part of the story telling was shorter yet more detailed. In my study, the content of the story specifically focused on the emergence of the mental health issue: **changing times**. The final stage presents the participants' *'self'* in their journey and current circumstances: *this is me*. Each stage was given a subheading. Since the first two stages set the context and are predominantly couple focused – **In the beginning** and **Changing times** set the scene about the couple's relationship together and denotes the beginning of and duration of the mental health illness. The last stage **This is me** focused specifically on the participant, allowing the story of their journey throughout the experience to unfold.

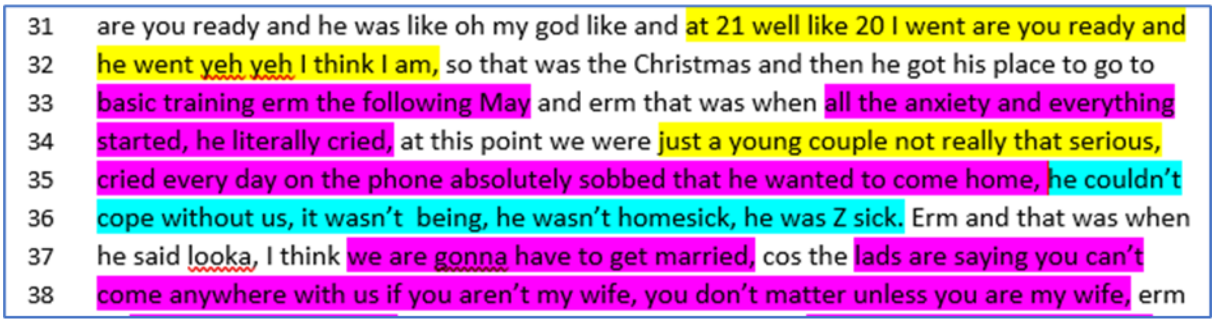
Figure 4: Example of initial analysis using the three stages



Participant 001 transcript

Beginning emergence of CMHD This is me

Photo's brought were a couple one following passing out parade and one when passed



are you ready and he was like oh my god like and at 21 well like 20 I went are you ready and he went yeh yeh I think I am, so that was the Christmas and then he got his place to go to basic training erm the following May and erm that was when all the anxiety and everything started, he literally cried, at this point we were just a young couple not really that serious, cried every day on the phone absolutely sobbed that he wanted to come home, he couldn't cope without us, it wasn't being, he wasn't homesick, he was Z sick. Erm and that was when he said looka, I think we are gonna have to get married, cos the lads are saying you can't come anywhere with us if you aren't my wife, you don't matter unless you are my wife, erm

Holistic-Content analysis

In order to capture participants' individual stories in each of the stages, holistic-content analysis was undertaken. The aim of the holistic -content analysis was to create a written account of each participant's story. As noted by Lieblich et al. (1998), stories can be constructed differently; especially between men and women, (Bruner, 1991). An example of this is evident in Harry's introduction, chapter 5. In addition, very often stories are not told in a linear manner (Lieblich et al., 1998. Lincoln & Guba, 1985), which then requires the researcher to re-story the participant's story (Ollerenshaw & Cresswell, 2002). Fundamental within the re-story, is the need to temporally order the events, actions and characters to the periods of time that they occurred, followed by interpreting how they then relate to each other and contribute to the end story (Bal, 1985).

To enable a temporally ordered description of each stage, the five-stage process of reading for context identified by Lieblich et al. (1998) was executed. The context of each stage was then categorised separately, dependant on whether they involved an **event,** an **action** or related to **interpersonal interaction** (Bal, 1985). See appendix 13 for example. These were utilised to formulate a textual description of each stage of participant's stories.

The story

I wanted to present the '*whole*' story as far as possible in the participants own words, however the role of the researcher in interpretating, analysing and rewriting must also be acknowledged. The previous sections illustrate how the stories were constructed from the narratives collected. The generation of the story involved transforming the actions, events and interpersonal interactions within each stage into sentences and then bringing the three stages together in order: *the beginning, changing times* and *this is me*. The sentences included raw data elements and narrative linkages to create the temporal description of what happened within each stage. To illustrate my role in the interpretation of the story, is to explain how much of the narrative was used in the final story, what was discarded and why (Fennell et al., 1988). Like Ford and Sinclair (1987), the desire was to produce an authentic picture of the person and their experiences from their own words which led me to deliberately withhold my comments from the interviews in the creation of the stories and this part of the analysis. A large amount of data was generated for each participant. Creating the story meant combining the data collected over two interviews which inevitably meant some data was edited and discarded. Indeed, Booth and Booth (1996) argue the necessity of the researcher playing the role of editor '*in reconstituting the transcripts as narrative'* (p66). Both interview transcripts for each participant were utilised to create the story. The title to each story was simply the pseudonym chosen by the participant at the time of interview (Clandinin and Huba, 2010) or given by me, along with representational quote which summarised his/her story. An initial paragraph describes some observations about the first time we met before presenting the story. Further demonstration in the editing and interpretation of their stories was participant involvement, such as choosing their own pseudonym (section: confidentiality) and reviewing pen portraits (section: life story interview). As highlighted in the section: confidentiality, concerns were raised over deductive disclosure for two of the participants. For that reason, parts of the transcript were discarded in the final stories.

Lieblich et al.'s (1998) framework enabled the opportunity to provide the couple's story from the participant's viewpoint to give the context and background; however, it is acknowledged that when the participants talked about their partners, it was from their perspective and their point of view and as such, presents only a part of the overall picture; their side of the story. When the stories relating to them as a couple were analysed, they were written in the third person. However, in the fleeting moments during the interviews when the participants referred to self, the first-person tense was used. It was important to me that part of analysis illustrated the participants themselves, that they were not invisible within their partners' stories nor that their stories were not fragmented in the production of categories. Maintaining the first person within the '*This is me'* part of the story, draws the participant out of the adjoined story, allowing the emphasis to be solely on them.

Categorical-Content analysis

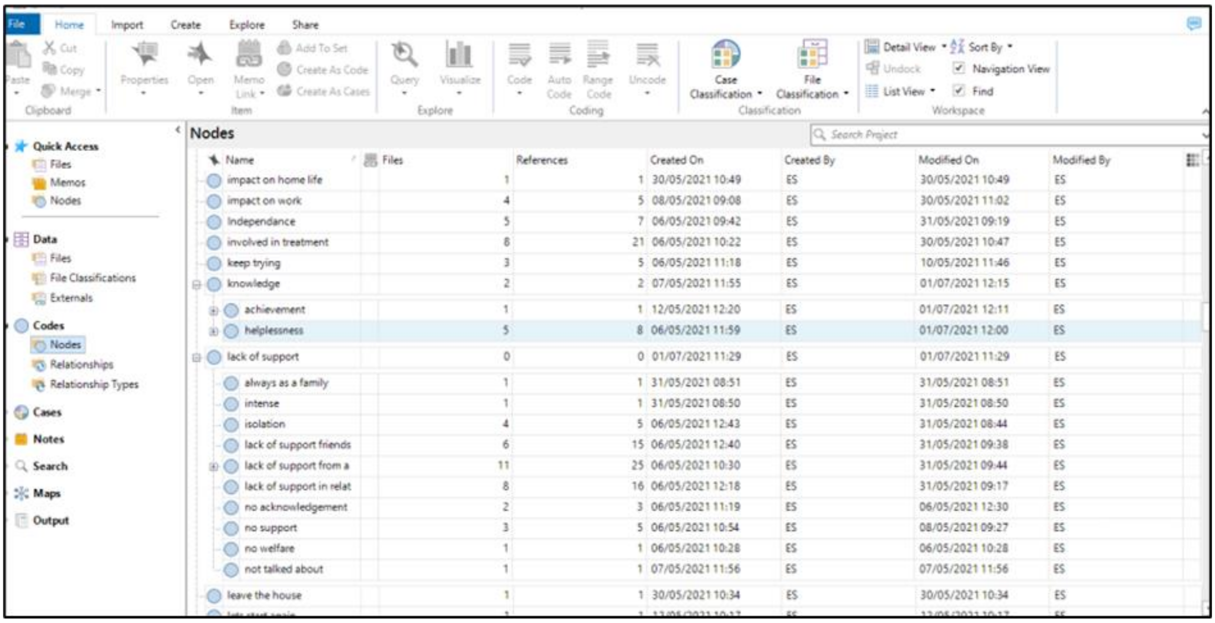
With similarities to thematic analysis suggested by Braun and Clarke (2006), Lieblich et al.'s (1998) '*Categorical-Content'* analysis was used to emphasize the interactions between the insights arising from the individual stories and the themes emerging collectively. Typically, content analysis centres on separate parts of the story content irrespective of the whole story.

Like holistic-form analysis, Lieblich et al. (1998) described two alternative approaches to categorical-content analysis. One approach has greater objectivity and accuracy, is easier to replicate or report on. It involves selecting subtexts specific to a research question, sorting and rating them according to frequency. The second approach is much more subjective and interpretive, and '*can reach more profound realms of understanding lives and experiences'* (p139). Unlike holistic analysis, whereby the findings remain individual, categorical-content analysis collates and reports the patterns found across the entire data set (Braun and Clarke, 2006). It allows for the comparison of structural elements and patterns along with the identification of difference or indeed, similarities across the participants' stories (Caddick, 2016).

In the first instance, this approach involves the complex process of interpretive interrogation of the entire transcript and not merely from a specific stage or event in the life stories. The identification of utterances leads to subcategories and then categories, which alongside a definition of interpretation demonstrates how the participants' presentations of themselves and their experiences have been understood. Underpinning such identifications of utterances requires explicit theoretical positioning so that the assumptions made during the interrogation of the data is transparent (Braun and Clarke (2006). For this study, I chose to take the second approach identified by Lieblich et al. (1998) which is more interpretive. Whilst more subjective, this approach aims to exemplify understanding of the lives and experiences of the participants in order to '*both reflect reality and to unpick or unravel the surface of reality'* as presented by them (Braun and Clarke, 2006, p81).

Prior to any identification of words and texts, I revisited the aim of the study which was to explore military spouses' experiences of living alongside their UK serving partner during a mental health issue. Initially, the entire transcript was read with words and texts highlighted (appendix 14). I revisited the references made to any aspect of the experience of living alongside a mental health issue that captured something important such as a description of a behaviour, a feeling or response regardless of size or prevalence. Such references were found throughout the transcripts; they appeared both spontaneously during the first interview and in response to the narrative generated questions used to deduce the participants' experiences during interview two: '*On a good day, what is it like for you?*' Immersing myself in the data previously to produce the stories, meant that I already held a deep familiarity with each of the transcripts and made the initial identification of words and texts seem almost effortless. All words and text concerning the observations, the emotional and material experiences and input were highlighted, listed and examined regarding the dynamic range they reflected (See figure 5). Utilising my supervision sessions, I shared some transcripts with both supervisors. I did this at this stage in the analysis to build confidence, I wanted to ensure that my initial thoughts were credible and that my initial findings were also recognised by experienced researchers. It also helped me to explore the *'fit'* between my representation and the participants views.

Figure 5: Example of initial analysis

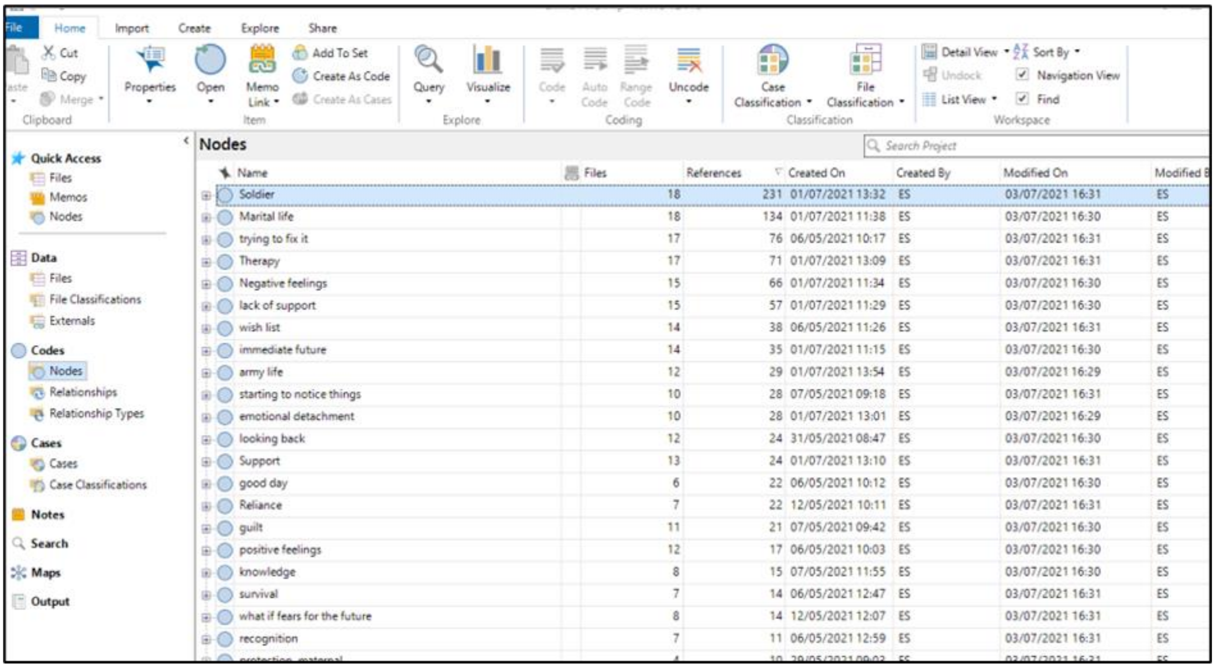


Nodes

Name	Files	References	Created On	Created By	Modified On	Modified By
impact on home life	1	1	30/05/2021 10:49	ES	30/05/2021 10:49	ES
impact on work	4	5	08/05/2021 09:08	ES	30/05/2021 11:02	ES
Independance	5	7	06/05/2021 09:42	ES	31/05/2021 09:19	ES
involved in treatment	8	21	06/05/2021 10:22	ES	30/05/2021 10:47	ES
keep trying	3	5	06/05/2021 11:18	ES	10/05/2021 11:46	ES
knowledge	2	2	07/05/2021 11:55	ES	01/07/2021 12:15	ES
achievement	1	1	12/05/2021 12:20	ES	01/07/2021 12:11	ES
helplessness	5	8	06/05/2021 11:59	ES	01/07/2021 12:00	ES
lack of support	0	0	01/07/2021 11:29	ES	01/07/2021 11:29	ES
always as a family	1	1	31/05/2021 08:51	ES	31/05/2021 08:51	ES
intense	1	1	31/05/2021 08:50	ES	31/05/2021 08:50	ES
isolation	4	5	06/05/2021 12:43	ES	31/05/2021 08:44	ES
lack of support friends	6	15	06/05/2021 12:40	ES	31/05/2021 09:38	ES
lack of support from a	11	25	06/05/2021 10:30	ES	31/05/2021 09:44	ES
lack of support in relat	8	16	06/05/2021 12:18	ES	31/05/2021 09:17	ES
no acknowledgement	2	3	06/05/2021 11:19	ES	06/05/2021 12:30	ES
no support	3	5	06/05/2021 10:54	ES	08/05/2021 09:27	ES
no welfare	1	1	06/05/2021 10:28	ES	06/05/2021 10:28	ES
not talked about	1	1	07/05/2021 11:56	ES	07/05/2021 11:56	ES
leave the house	1	1	30/05/2021 10:34	ES	30/05/2021 10:34	ES

Unlike Lieblich et al. (1998), however, I did not begin this analysis with any preconceived thoughts of what or how the subcategories would look like. A range of subcategories were identified from the hundreds of utterances highlighted; initially 37 different subcategories illustrating different aspects of the participants experience were created (figure 6). At this point, I recognised that some of the categories held similarities to those identified in the literature review such as knowledge, impact on home life (chapter 2).

Figure 6: Illustration of 37 categories in Nvivo

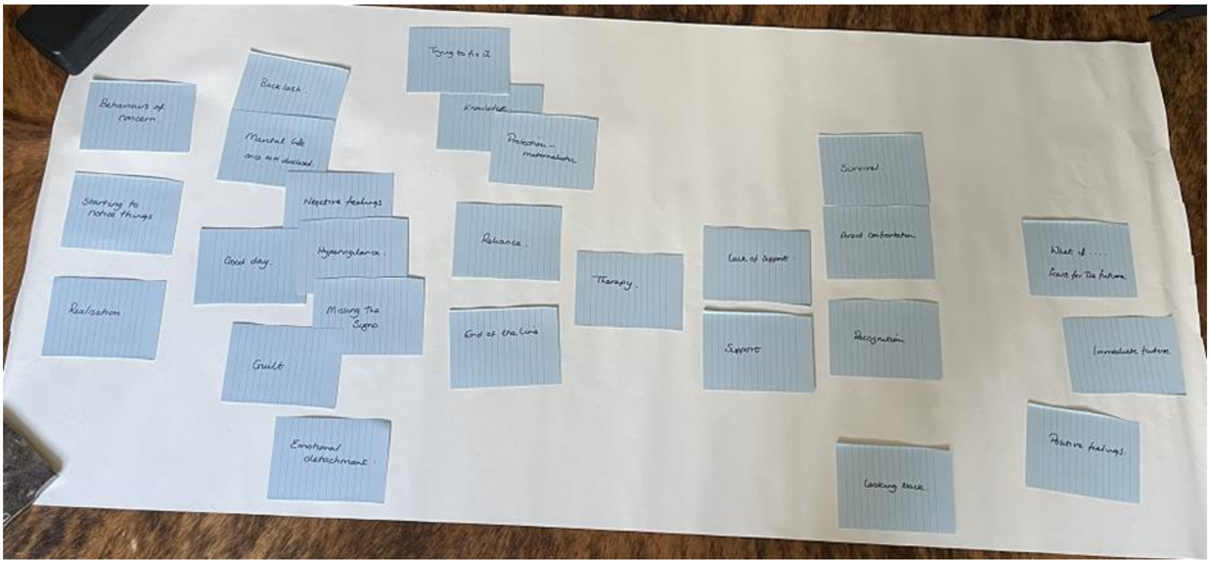


Nodes

Name	Files	References	Created On	Created By	Modified On	Modified B
Soldier	18	231	01/07/2021 13:32	ES	03/07/2021 16:31	ES
Marital life	18	134	01/07/2021 11:38	ES	03/07/2021 16:30	ES
trying to fix it	17	76	06/05/2021 10:17	ES	03/07/2021 16:31	ES
Therapy	17	71	01/07/2021 13:09	ES	03/07/2021 16:31	ES
Negative feelings	15	66	01/07/2021 11:34	ES	03/07/2021 16:30	ES
lack of support	15	57	01/07/2021 11:29	ES	03/07/2021 16:30	ES
wish list	14	38	06/05/2021 11:26	ES	03/07/2021 16:31	ES
immediate future	14	35	01/07/2021 11:15	ES	03/07/2021 16:30	ES
army life	12	29	01/07/2021 13:54	ES	03/07/2021 16:29	ES
starting to notice things	10	28	07/05/2021 09:18	ES	03/07/2021 16:31	ES
emotional detachment	10	28	01/07/2021 13:01	ES	03/07/2021 16:29	ES
looking back	12	24	31/05/2021 08:47	ES	03/07/2021 16:30	ES
Support	13	24	01/07/2021 13:10	ES	03/07/2021 16:31	ES
good day	6	22	06/05/2021 10:12	ES	03/07/2021 16:30	ES
Reliance	7	22	12/05/2021 10:11	ES	03/07/2021 16:31	ES
guilt	11	21	07/05/2021 09:42	ES	03/07/2021 16:30	ES
positive feelings	12	17	06/05/2021 10:03	ES	03/07/2021 16:30	ES
knowledge	8	15	07/05/2021 11:55	ES	03/07/2021 16:30	ES
survival	7	14	06/05/2021 12:47	ES	03/07/2021 16:31	ES
what if fears for the future	8	14	12/05/2021 12:07	ES	03/07/2021 16:31	ES
recognition	7	11	06/05/2021 12:59	ES	03/07/2021 16:31	ES

Moving forward, this required further refinement and growth. Through ongoing interpretative dialogue of the transcripts both on my own and further discussion with my supervisors, I refined the number of subcategories from 37 to 26 (figure 7).

Figure 7: Initial mapping of the 26 categories

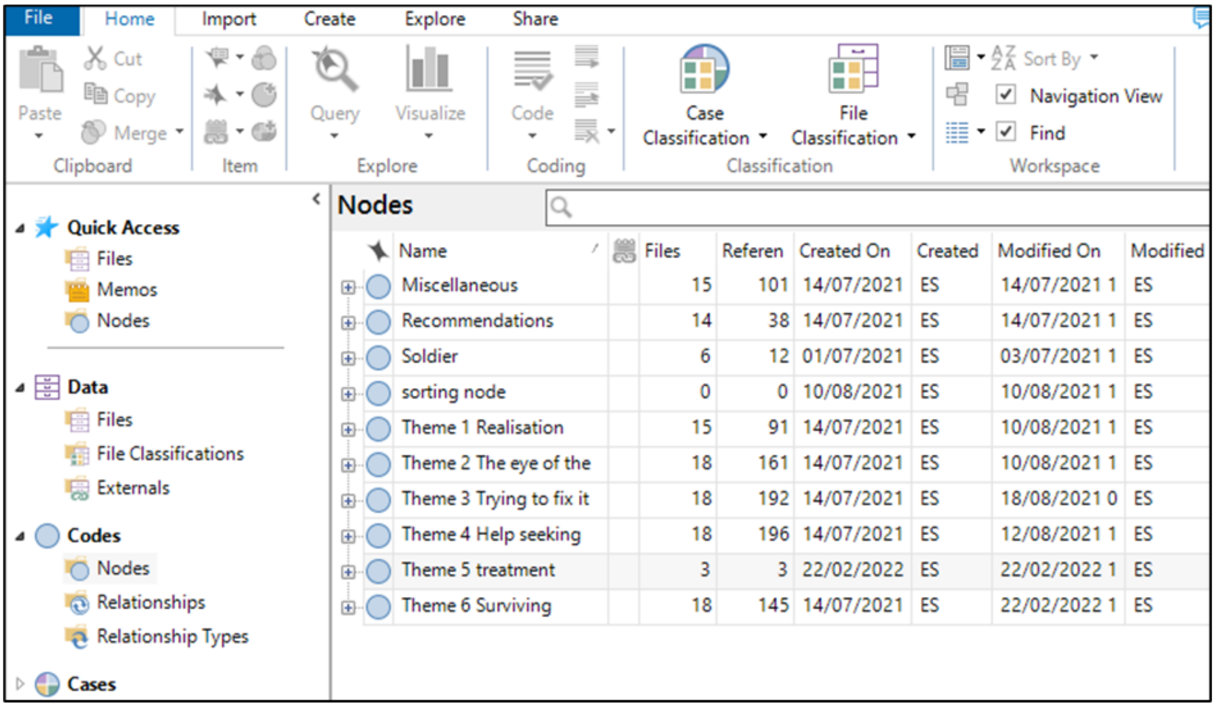


From the 26 subcategories, I then formulated seven main categories by grouping subcategories together that were of similarity or from the same period of time (figure 8).

Figure 8: Illustration identifying the seven main categories

After further interrogation and interpretative dialogue with the subcategories and categories, I reduced the number again. This was a result of similarities and/or how the quotes coincided or complemented each other. To that end, I identified 21 subcategories situated within six categories, (figure 9).

Figure 9: The six categories in Nvivo

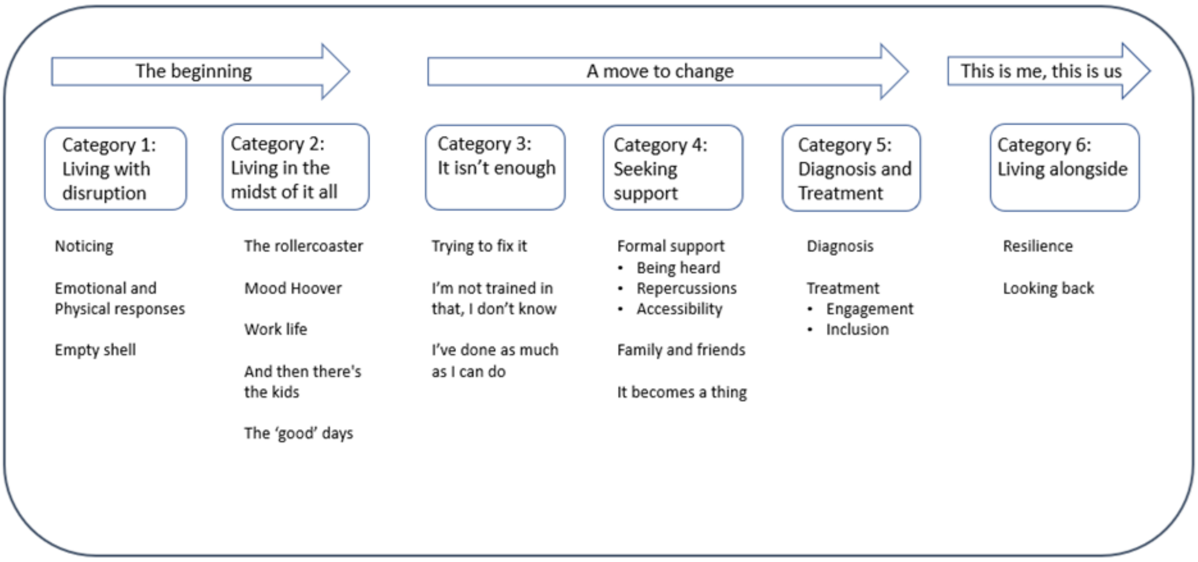


Nodes

Name	Files	Referen	Created On	Created	Modified On	Modified
Miscellaneous	15	101	14/07/2021	ES	14/07/2021 1	ES
Recommendations	14	38	14/07/2021	ES	14/07/2021 1	ES
Soldier	6	12	01/07/2021	ES	03/07/2021 1	ES
sorting node	0	0	10/08/2021	ES	10/08/2021 1	ES
Theme 1 Realisation	15	91	14/07/2021	ES	10/08/2021 1	ES
Theme 2 The eye of the	18	161	14/07/2021	ES	10/08/2021 1	ES
Theme 3 Trying to fix it	18	192	14/07/2021	ES	18/08/2021 0	ES
Theme 4 Help seeking	18	196	14/07/2021	ES	12/08/2021 1	ES
Theme 5 treatment	3	3	22/02/2022	ES	22/02/2022 1	ES
Theme 6 Surviving	18	145	14/07/2021	ES	22/02/2022 1	ES

I then culminated these into a conceptual framework illustrative of a journey. This journey is depicted under the headings: the beginning, a move to change and this is me, this is us; the depiction of a journey is typical in biographical research (Plummer, 1995; McAdams, 1997), (figure 10).

Figure 10: Conceptual framework of the journey



4.10 Handling the data

Undertaking two in-depth interviews with each participant generated an extensive amount of data. As such, consideration of how to handle the data was required. Initially I had intended only to code the data manually without the use of Computer Assisted Data Analysis Software (CADAS). Naïvely I thought having to learn about CADAS would take valuable time away from data analysis and present a barrier which would prevent me from becoming immersed in the data. Indeed, Clarke (2009) favours manual coding as it affords an '*intimacy that cannot be achieved otherwise'* (p 70). To that end, the data was manually coded for the creation of the whole stories. This did allow me to fully immerse myself in the data; however, when moving to interrogate the data for the category-content analysis, I found that the sheer amount of data became unmanageable. The CADAS programme NVivo™ was used. Despite my initial reservations about using NVivo™, it proved invaluable in the organisation and management of my data. The use of CADAS is supported by many researchers who argue it is the intention not to replace traditional methods but increase the effectiveness and efficiency of time spent (Bergin, 2011; Bazeley and Jackson, 2013; Silver and Lewins, 2014). NVivo™ provided me with a single repository to store and organise my digital recordings and interview transcripts (Silverman and Lewins, 2014). Similar to my initial reservation of using a CADAS programme, a criticism noted by others is that it can create distance between the researcher and the data (Bazeley and Jackson, 2013; Tummons, 2014). As highlighted earlier, I transcribed each interview myself and I had initially immersed myself in the data to create the whole stories which proved invaluable since they provided me with a deep familiarity of the data and as such, I did not feel distanced from it. I continued to revisit the audio recordings, interview notes and transcripts throughout the category-content analysis as Bazeley and Jackson (2013) argued, the combined use of all data types promotes deeper analysis. NVivo™ was used to first identify utterances within the transcripts, and then to organise them into subcategories and then categories as described in the data analysis section. In addition, NVivo™ supported the development of word clouds to report the data differently and illustrate new ideas (Bazeley and Jackson, 2013). It creates a visual image of the words used within the transcripts; however, it is pertinent to remember that just because participants say a word a lot or mention a word does not necessarily mean it is the most important thing to them. Some participants may not disclose the things that might concern them the most (Lee, 1999; Plummer, 2006).

Word clouds can however be a useful and impactful illustration when presented alongside in-depth description of findings in their context.

4.11 Quality measures in this research

This section illustrates the quality measures applied in this research. Within qualitative research, rigour is used to indicate and evaluate the quality of the research (Liamputtong, 2019). Tobin and Begley (2004) suggest that ‘rigour’ is the way the research process is legitimised, how integrity and competence is demonstrated. They argue that without the consideration of rigour, the research is in danger of becoming “*fictional journalism, worthless, as contributing to knowledge”* (p390). It is a similar concept to that of validity (stability) and reliability (truthfulness) of findings from the positivist research paradigm (Carpenter and Suto, 2008). It has been well debated that applying measures to qualitative research from a positivist standpoint is problematic, with research seen as too subjective, unscientific and subsequently deprived of legitimacy (Angen, 2000; Liamputtong, 2019). The consensus is that validity and reliability are discordant with the ontological, epistemological and methodological underpinnings of qualitative research (Whittermore et al., 2001; Carpenter and Suto, 2008; Polit and Beck, 2014, Liamputtong, 2019). Some qualitative scholars, however, have argued against the consensus, suggesting that by rejecting the positivist measures of reliability and validity denies the scientific value of qualitative research as a development of knowledge (Morse, 2002; Tobin and Begley, 2004; Hammersley, 2008). Consequently, alternative criteria for assessing the merits and trustworthiness of qualitative research were explained in Guba and Lincoln’s (1985) seminal text. Although there are some concerns about such ‘checklists’ and adherence to universal criteria since they do not provide flexibility to accommodate diverse approaches often found in qualitative studies (Dixon Woods et al., 2004). The quality measures of credibility, dependability, confirmability, and transferability along with authenticity as a later edition (Lincoln and Guba, 1994) are still widely considered appropriate for qualitative research (Polit and Beck, 2014; Liamputtong, 2019). Table 6 below illustrates how these measures have been applied within this research.

Table 6: Trustworthiness of the study

Trustworthiness criteria	Examples in this study
Credibility and Authenticity- comparable to internal validity. To provide an authentic representation of the data and its interpretation. It relates to endeavouring to ascertain confidence in the findings in terms of both the participants and the research context (Polit and Beck, 2014; Liamputtong, 2019). Also, refers to the degree to which the different realities have been 'fairly and faithfully' represented within the study (Polit and Beck, 2014).	Pen portrait given to participants prior to second interview Clarification of points made during second interview Written memos and interview notes made during interviews Digital recordings of interviews taken and transcribed verbatim Sharing of transcripts with supervisors Discussion of findings with supervisors Engagement with post graduate research training and peer support Provide direct quotes from participants
Dependability- (reliability) refers to the stability of the study's data over time and in similar conditions. It is the steps taken that ensure consistency and that the study's processes could be followed (Polit and Beck, 2014; Liamputtong, 2019).	Description of systematic narrative literature review Audit trail of research process Supervision and progress reviews Presentation at conference (x2) to receive peer feedback Literature review feedback from submission for publication

Transferability-external validity, the degree at which the results can be transferred or hold applicability for other groups or in other settings (Tobin and Begley, 2004; Polit and Beck, 2014; Liamputtong, 2019)	Describe the context of the study and provide rich, in-depth description of findings and conclusions to allow others to judge the applicability Clear description of sampling – purposeful sampling
Confirmability- comparable with neutrality and objectivity; how the researcher demonstrates confidence in the interpretation, the accuracy, meaning and relevance of findings and conclusions (Polit and Beck, 2014; Liamputtong, 2019).	All of the above

4.12 Reflexivity work

McLeod (2011) states that it is the personal nature of qualitative research that is one element which differentiates it from positivist approaches. The notion that qualitative research is a personal activity which requires the development of relationships, personal struggles through challenging assumptions and generating new understandings is alluded to earlier (see chapter 1 and 3). Furthermore, the personal experiences and identity of the researcher will inevitably influence the findings (McLeod, 2011 Liamputtong, 2019; Merrill and West, 2014). Acknowledging the personal within qualitative research is known as '*reflexivity*' (McLeod, 2011; Alvesson and Skoldberg, 2017). Reflexivity as notion is familiar territory within health and social care practice and could be surmised as an expected norm within qualitative social science research. However, there are some disciplines such as psychology where reflexivity is contested, with some theorists believing that true reflexivity of self is an unattainable goal (Parker, 1994). Developing ways to be reflexive was considered integral to this study, particularly given my *'insider'* role as a military wife; supporting '*the integrity'* and '*nature of the knowledge'* in order to produce a more robust, credible study (Carpenter and Suto, 2008; Liamputtong, 2019, p25).

Hunt and West (2009) suggest that reflexivity:

> '*Requires sensitivity towards the self and others, to feeling as well as thoughts and to what may be difficult for us, as researchers, to engage with and understand, because of our own life histories and psyches*' (p77).

McLeod's (2011) key principles for reflexivity resonate and were adopted for this study. He suggested reflexivity involves having an awareness of the moral dimensions within the research, demonstrates consideration of the processes through which text is co-constructed and be open to new approaches to writing and disseminating the research findings (p196).

Within all qualitative research there is a moral dimension, with many researchers suggesting that this dimension is sufficiently included through the attainment of ethics. However, some, such as Frank (1995), argue that the moral dimension surpasses the inscribed ethics and considers areas such as the emotional impact of the research on the participant, of seeing their stories in print, alongside researcher anxiety surrounding their representation of the stories and the emotional labour in managing their own emotions (Campbell, 2002). Within this study, a number of dilemmas and points for consideration arose, and it was necessary to interrogate myself in relation to key areas of the research process (Merrill and West, 2014).

Embarking on this study, I was acutely aware that I had in the past, lived through the experience that I was about to study. While the experience and my identity as a military wife had informed the study, I was concerned that my story would get in the way; so, prior to carrying out any learning for this study, I wrote my story in full. Just as the participants gave in their first interview, I produced as Rosenthal (2004) states a '*biographical self-presentation*' of my story. I did nothing with it, simply wrote it and then filed it away. Whilst aware of its existence, the therapeutic nature of writing my story enabled me to move beyond the experience and empowered me to move forward with the study. In the initial years I debated with myself and my supervisors about whether to include it in its entirety. I concluded that inclusion of the whole story was not in the best interest for my husband, myself and for the study. I deemed it sufficient to include only the necessary points. The detailed and depth of the stories in this study belonged to the participants, they are the central focus of this research.

There is much debate surrounding *'insider'* status, within feminist research. For some, it is viewed as a guiding principle (Stanley and Wise, 1983; Oakley, 1992) yet for others, especially those rooted in the positivist paradigm, it yields words of caution. Comparable to the beliefs within feminist research, the fact that I had been a military partner, like the participants, did go some way to promoting trust and build rapport; key factors within social science research, (Bathmaker & Harnett, 2010; Gorad, 2013). This was evident with all the participants accepting my knowledge and insight of military life. Indeed, two participants during their interviews gave comments such as '*well you are one of us really*', Lindy (participant 2) and '*I only agreed to do this because you are one of us'*, Cathy (Participant 6). During the interviews and conversations post interview, the experience of the serving partner being away on tour and the home experience were discussed; whilst this was not the focus of the study, the sharing of the experience and the commonality that eluded from the discussion seemed to provide acceptance and credibility for both of us. Whilst such comments gave welcomed reassurance, it did heighten my anxieties about producing authentic representations of the participants. As highlighted in chapter 3, it was always my intention to represent participants' whole stories, as well as the parts (the categories) within them. Through the use of pen portraits (see below heading, the interview space) and identifying a framework to support analytical pluralism (see section on data analysis for detail), I was able to reduce my anxieties somewhat by finding new ways to write and produce findings that were authentic to the participant story alongside the interpretation of categories.

As suggested earlier, the moral dimension and the research process not only includes the researcher, but also participants. The impact of the research on participants such as seeing their stories in print were areas to consider. The participants were unknown to me, so entering into the interview space was an unknown entity in knowing the participants emotional threshold; the reactions and responses that would prevail. My professional experience as a nurse, health visitor and sexual health advisor, afforded me excellent communication and interpersonal skills, enabling me to enter the interview space with ease. However, as both Clarke (2000) and McLeod (2011) suggests, entering into the interview exchange with excellent skills can have greater impact on the participant than a poorly conducted interview as the participant's is more likely to open up and share in detail their experiences. Whilst not an experienced researcher, I have extensive experience of assessments and sharing difficult news. Fundamentally the underlying principles of non-verbal and interpersonal skills are transferable and as such I had anticipated the possibility of emotional difficulties arising. However, I was mindful that the role of a researcher differentiates from that of a healthcare practitioner. As a researcher I was not there to provide solutions or guidance in addressing difficult situations, however as a feminist researcher (see chapter 3), if required, I was able to share parts of my experience which is something I could not do in healthcare. Two areas arose from within the interview space, one was the response of the participants to their pen portrait. For the majority, the reading of their story triggered a greater emotional response than during the sharing of their story. For some, they voiced their emotions such as Cathy (participant 5) who said '*it's so sad, all this time until now'* whereas for others, it was it was more non-verbal, a change in their facial expression or a tear. This response opened the conversation and led to the verification of the interpretation and ultimately credibility. On reflection, I had entered into the space naïvely, listening to the stories evoked likenesses to my own memories. After some interviews, I found myself entering a dark place, at times, one from which I felt I could not continue with study. Dickinson-Swift et al., (2008) confers that researcher can feel overwhelmed and frustrated should they try to suppress the emotions felt during interview. Whilst naïve about the intensity of the impact, I had at the beginning of the study considered this and identified supervision as a mechanism of support. I had thought my experience of dealing with emotive experiences in my professional life would have been enough preparation; however, I did require support through supervision and peers.

4.13 Chapter conclusion

This chapter has provided a detailed overview of how this study was conducted using a biographical approach and methods. I have presented a rationale for using biographical research which has clear links to my conceptual thinking discussed in chapter 3. I have described the participant recruitment and selection process and how the stories were captured and co-constructed underpinned by key ethical considerations. The data analysis discussion gives a detailed account of the framework adopted to achieve plural analytical processes. Finally, the importance of reflexivity and some of the dilemmas faced are discussed. The following two chapters presents the findings generated from the two different analytical processes.

5 Chapter 5. Presentation of findings: The stories

5.1 Introduction to chapter

This chapter presents the findings from the participants' two interviews. Initially, participant and relationship characteristics are presented. Also included is the spouse's mental health issue identified by each participant. The holistic analytical approach of Lieblich et al.'s (1998) framework was used to write the participants' stories. As described in more detail in chapter 4, given the subject matter and the aims of the research, it was important to consider the stories as a whole prior to extrapolating themes from within and across the narratives (chapter 6). Whilst Lieblich et al. (1998) identified four single approaches to narrative data analysis, they suggest that analysis need not fit into one approach only. Within '*holistic'* analysis, each individual story is considered as a whole and the parts within it interpreted in context to other sections of the narrative. To this end, a combination of *'Holistic-Form*' and '*Holistic-Content'* analysis was used for each story. Within '*Holistic – Form,'* a two-stage life story analysis was undertaken to demonstrate story structure which is '*dominated by a single idea, which then provides an anchor for restructuring the teller's memories'*, (Lieblich et al., 1998, p106). The two-stage life story analysis identifies three distinct stages: a '*before and after a major life change'* with a shorter mediating stage of transition. The beginning stage is the long, undifferentiated period with many years and events collapsed into one. The middle stage is the active, transitional point which is described in more detail and the final stage, presents a point of actualisation (Lieblich et al. 1998).

To reiterate, my study explored military spouse's experiences of living with their UK serving partner during a mental health issue and therefore was specific to a particular period and a specific focus. As explained in chapter 4, the starting point in the first interview was left up to the participant to decide; I simply requested *'tell me your story*'. Most participants' stories began when they met their partners. Initially, what emerged from the interviews was a collection of years and events which set the scene about their relationship. Similarly, to Lieblich et al.'s (1998) findings, during interrogation of the data, I collapsed these events into one as they were indicative of the beginning stage and named as such. As in Lieblich et al.'s study, the second part of the story telling was shorter yet more detailed. For my study, the content of the story focused on the emergence of the mental health issue: changing times. The final stage presents the participants' '*self'* in their journey and current circumstances: ‘this is me’. Each stage was given a subheading, and these are depicted in the individual presentation of the stories. Whilst the first two stages set the context and are predominantly couple focused – **In the beginning** and **Changing times** set the scene about the couple’s relationship together and denotes the beginning of and duration of the mental health issue. The last stage, **This is me**, written in the first-person tense focused on the participant, allowing the story of their journey throughout the experience to unfold.

As previously argued (chapter 3 and 4), the desire for the participant voice was paramount, so stories are presented as much as possible using participants’ own words. Throughout each story, pseudonyms (chapter 4) have been used and the participants’ actual words are represented in italics.

5.2 Participant characteristics

It was not my aim to collate specific demographic data around each participant; however, some details emerged during the interviews that are interesting to note. Detail about the participants selected for this study are presented in table 7.

As discussed in the earlier chapter under the heading participant recruitment, other studies identified ‘*obedience duty’* as a further barrier to recruitment. Whilst I had made the decision to recruit outside of the confines of the military organisation, a noteworthy finding was that the notion of ‘*obedience duty’* did not seem to hold any influence over most of the participants taking part.

At some point during their interviews, all participants mentioned that they had discussed their involvement in my study with their serving partners. The consensus from the participants’ perspective, barring one serving partner (Lindy) was that the serving partner was happy for their partner to be involved. At the time of the interviews, Lindy’s marriage was the most fragile, which may be one explanation as to why her serving partner wasn’t as encouraging. I also think that there was a strong element of ‘*obedience duty’*, Lindy expressed this obedience and loyalty to the army throughout her story. In contrast, Harry contacted me after his wife (serving partner) picked up one of the postcards I left following a talk with one of the military partners organisations. This was a surprise to me; one reason being that because of the previous literature highlighting ‘*obedience duty,’* I did not expect a serving partner to encourage participation in my study. The relevance of this however, demonstrates that the serving person themselves was at this point aware of their mental health issue.

Table 7: Participant characteristics

Name	Age bracket 18-25 26-35 36-45 46-55	Marital status	Relationship length: 0-5 years 6-10 years 11-15 years 16-20 years 21+ years	Accommodation type: Own home (OH) Private rented (PR) Military housing (MH)	Serving partner employer: Army Navy RAF	Serving Partner rank: Commissioned (Officer) Or Non-commissioned (Other ranks)	Serving partner mental health issue: Adjustment disorder (AD) PTSD Depression (D) Anxiety (A) Post-natal depression (PND)
Christina	18-25	Married	6-10	MH	Army	Non-commissioned	A & D
Lindy	46-55	Married	21+	OH & MH	Army	Commissioned	AD / PTSD
Simone	26-35	Married	6-10	MH	Army	Non-commissioned	D & PTSD
Lauren	26-35	Married	6-10	MH	Army	Non-commissioned	D
Harry	26-35	Married	6-10	MH	Army	Commissioned	PND
Cathy	36-45	Married	11-15	OH & MH	Army	Non-commissioned	A & D
Sara	26-35	Married	11-15	OH	Army	Non-commissioned	D & AD
Vikki	36-45	Married	16-20	OH	Army	Non-commissioned	D
Sophie	36-45	Married	21+	OH	Army	Non-commissioned	D

5.3 The stories

Christina:

'in a nutshell it's hard, but you love them don't ya'

Christina and I were acquainted prior to the interview meeting. Whilst I knew Christina as a student and as a military wife, I had no knowledge of her relationship or that she met the criteria for my research until we were chatting one day, and I asked her to share my promotional materials within her military spouse network. Christina asked about my research, I told her, and she simply replied, '*I'd like to be one of your participants, my husband has problems with anxiety*'. Christina was my first participant. We met for the interview in a small comfortable office on the university campus. Christina had been a student at the university and chose this as the location of the interview, stating that she felt at ease with her surroundings. Once the formalities had been completed, Christina shared some photographs of her and her husband: a good starting point for her story which she shared with ease, even though a range of emotions were displayed throughout. There were a couple of points where Christina became emotional with tears welling in her eyes when she spoke of Daniel's behaviours (discussed in chapter 4) but there were also some expressions of *'triumph'* when she talked of her achievements.

In the beginning……..

Christina and Daniel *met at school* and, by the *age of seventeen, were mixing with the same group of friends in sixth form* college. They socialised *together for about eighteen months before they started dating*. Christina had *always wanted to do nursing* and had considered that a route to meet that dream would *be through the army*. *About three to four months* into her relationship with Daniel, Christina went along to the *army careers* recruitment to find out more. *Family life* meant that Christina's dream of becoming a nurse through any route was on hold. Christina secured a *job at the local hospital*, *moved out of home and financially supported herself*.

Daniel had a 'textbook' normal upbringing, although Christina felt that *he just wasn't really loved*. *His parents divorced when he was a teenager around the time* that Christina and Daniel *met*. From then on, Christina *mothered Daniel* because *that was what he had needed;* she said that she had *always been like a mum* to Daniel*.*

Just like Christina, Daniel had career ideas, *he wanted to join the army and didn't really try at school because he didn't need it to join.* Christina's attendance at the army recruitment was the motivation for Daniel to go too. Christina felt that *he got a little bit jealous and thought it's me that wants to be in the army*. *Four months later, a position was available to sign up* to the army. Daniel was *18 years old* and unsure whether *he was ready*. On noticing Daniel's uncertainties, Christina said *'get a job in civvy life, see what it's like being an adult'*. Daniel *declined* the army position and worked as a fitter *for a signs company*.

Three years after meeting, Christina and Daniel *moved into a flat together* and whilst *not really that serious*, they *were quite established as a couple*. *At the age of 21*, *at Christmas time,* Daniel was contacted by the army and *offered a position*. Christina said, '*what about it then, are you ready to join?'* Daniel joined the army and *began his basic training the following May.*

Changing times……..

According to Christina, leaving for basic training was the *start of Daniel's anxiety; he literally cried every day*. Daniel told Christina that *it wasn't missing home, it was being 'Christina sick'*; he missed Christina. A few weeks into training, Daniel suggested to Christina that they were *going to have to get married because 'the lads are saying you can't come anywhere with us if you aren't my wife, you don't matter unless you are my wife'*. Christina agreed to marry Daniel *and she said it was a total whirlwind*. Daniel *passed out of training on the Friday, they were married on the Saturday and Daniel went onto his second phase of training on the Monday*. Christina said that she *loves to socialise* and was looking forward to *meeting new people.* According to Christina, Daniel, however, *wasn't the typical soldier type, he didn't go out socialising or drinking; he preferred being alone* with Christina, *going camping, doing quiet things*. Christina *was really lonely*, but Daniel *promised that they would meet people, make friends with other army wives.*

The *second phase* of army training lasted *a year* and was based approximately 300 miles away from Daniel and Christina's flat. Christina moved with Daniel into army accommodation, and *they spent a year away from home as a newly married couple*. Christina *worked in a care home doing agency work* while Daniel completed his army training. Meeting friends never really happened, for two reasons; Christina felt like *a bit of an anomaly on the street; somebody that was working,* and every time Christina started to meet somebody, they would be invited *round for tea*, but Daniel would *say 'no, no I don't want to go, I don't want to socialise with someone from a different unit or a high rank'.* In the months leading up to Daniel's end of training, Christina *moved back home two months early* and they spent the last months of his training apart.

Daniel completed his training and received a posting near to their hometown. Christina said that this was a new opportunity for them to *start again*. Christina found *employment in a care home*. About a year into this posting, Daniel was told that he would be sent on *a tour in Afghanistan the following year*. Whilst away in Afghanistan, Daniel reported *no incidence* of *traumatic events* or *anxiety* and told Christina '*it was one of the best times of his career'*. Whilst Daniel was away on tour, Christina began to make *friends with other wives and their husbands*. One of the *biggest barriers* for Christina *was not having children; the mums got to go to classes because they* (army*) put things on, and they were really good*. Once Christina got to *know some of the mums*, she then *attended* events *without a child*, but *it was always a bit odd;* however, the bonds made during this time meant that the friendships Christina made remained strong. On Daniel's return from Afghanistan, Christina *often worked weekends*. When Christina was not at home on Daniel's days off, he *would go and stay back at their hometown* with his mother instead of their family home. Daniel *never seemed happy* alone in the family home.

From Christina's perspective, Daniel's army career continued to go well; he *received good reports*, *he was good at his job* and *was very much a 'yes' man in work*. Throughout his career, Daniel had *always suffered* with episodes of *anxiety*, but his anxiety and stress had worsened in recent years. Christina felt that he *always wore a 'game face' on at work;* no-one was aware of his increased anxiety. In 2015, Christina secured a *place in university* in her hometown *for nurse training*. Despite a continuation of posting in the local area, Daniel was then *posted* 300 miles *away again to complete his Class 1* (trade specific) *training for six months*. Christina *started* her *nurse training on a Monday*, Daniel left the day before. It was then that Christina observed that Daniel's symptoms of separation anxiety were worsening to the point of seeking treatment. Leaving home for six months appeared to have triggered *a separation anxiety thing* for Daniel and he experienced *some sort of panic episode* which left him unable to undertake daily requirements of his role. Christina said that Daniel was telling her *he couldn't cope* and that *he was actually getting to the point where he was saying 'I'll just crash my motorbike and hurt myself enough I won't have to go to work'.* At this point, Daniel *attended the medical centre*, *had a chat with someone* and they set him up with *some counselling sessions and suggested that he just cracked on with the troops rather than sit in his room*. Despite the physical distance between them, Christina also started to search on the internet for possible explanations for Daniel's symptoms. Christina found a web page explaining depression depicting it *as a black dog which sits on your chest and gets bigger and bigger*. Christina shared this with Daniel and *asked him to read the article*. Daniel rang *Christina* in an *almost childlike* fashion *saying, 'oh my god that's so me, I have a black dog that sits on my chest all the time'.*

The counselling sessions went on *over a six-month period* and then *fizzled out*. Christina felt that the *counselling did help*; Daniel became less reliant on Christina and a lot *more independent*. Alongside the counselling, Daniel was *offered medication but declined to take it.* During the first days on Christina's nursing course, she recognised that she *was distant and never really engaged with anybody*. Christina's *concentration was on Daniel*.

Christina and Daniel spent the next three years living apart; Daniel had been promoted *following his training* and posted away to another area of the country whilst Christina remained at university, where they *bought a house* together. Over these three years, Daniel's *anxiety* had manifested *to the point* where he *suffered really bad chest pain* and *a tightening in his throat;* again, he sought *medical attention* at Christina's request. Preliminary diagnostic *tests were all negative*, Daniel was *prescribed omeprazole for gastric reflux* and Christina was *sure he was also offered counselling*. Daniel declined to *engage in either treatment option*. Daniel's *depression and anxiety are on-going* and with this, Christina said that Daniel could *become angry out of nowhere, smash things up in frustration*. In some ways, Christina felt that the *army life exacerbates this with the 'hurry up and wait' stance taken*. Daniel often described to Christina the feeling *of being trapped*, *that his life is not in his control*, but Christina said that, despite this, *he is married to the army, and he loves it.*

This is me……..Christina

As a newly married couple it was really hard; hard for both of us. I was away from my family, a young girl, working in a care home. *Being away put a massive strain on the first year of marriage, it got so hard that with two months left I couldn't do anymore, I didn't leave* Daniel, *but I just had to go home*. *It's horrific to think that it got to that point*. Daniel *likes to keep me with him, I'm quite a bubbly, chatty person and I love to socialise, but* Daniel *isn't really so he sometimes struggled with me making friends wherever we went, especially when he was away in Afghanistan. I was nervous when he came back, but he was actually really good.*

It’s just like a rollercoaster, there are periods that are settled and then *it is unreal again*, *I have sometimes thought I don’t know if I can do it, but I have just got to be there for him. It does put a huge strain on the marriage though.*

When Daniel *went away, that’s when it really started, I’ve said to him, ‘emotionally you are unstable don’t go’, but he would still go, it was horrendous. It’s really hard because I’ve been miles away every time. No-one at work knows Daniel has these problems but he came home and it’s just like woah, it was quite child-like, and I felt motherly towards him*. It was *heart-breaking to see him like that* and *I often said is the job worth it.* Daniel gets so chewed up and at times mentioned hurting himself which left *me feeling helpless and not knowing how to help him, it was exhausting. There are times where I have thought ‘do I really want to do this for the rest of my life? Is this what marriage is like?’*

When I started the nurse degree, things changed. In the past, if Daniel was away and struggling, *I would have put some leave in whatever job I was in and went down there* but *the fact* this time *I was stuck* once the degree started. *I wouldn’t have given that up* like I had done with other jobs. *I wasn’t nervous on my first days* in university, *it was just that I was drifting*, *I was constantly looking at my phone and that’s not like me, I was ringing him, I was so distracted from here for my first month. I would say my head was down there, even though I wasn’t there. It was sad, I felt like as much as I’d tried so hard to support and help him, it wasn’t enough. A part of me thought was he being like this ‘cos I’m not with him, because I’m on the course, I’m doing something for me and by doing so is making him worse.* It was *just horrible, I felt totally helpless* but was *also angry*. I think *the three years actually did us good because he realises that actually my degree comes first*. Daniels *always been my number one and I’m always giving me 100% but he’s never really gives it back* because of *his job. I’ve always accepted that, always have and always will. I’m never first but I get it, for the most it’s not his choice and that’s fine but even when I could be his first, I never really am and that’s hard. It’s like an unconditional/non-conditional relationship where I literally would bend over backwards for him, and he can’t and then just doesn’t. My life always revolves around his* and *in a nutshell, it’s hard, but you love them. You sacrifice a lot but then you gain a lot. I reached the point where I felt like I’d done as much as I can do in the whole relationship, and it took us a while to settle back down.*

Daniel went for counselling during those *beginning six months,* and *he just suddenly became really shut off, it was awful*. *He would ring and then just not speak, be* *totally silent and I would try to fill the void whilst feeling helpless that I couldn't help him and really angry that he wouldn't open up.* During *the time of the counselling,* Daniel *did improve and I'm not sure then if I felt hurt but there was a mixture of feelings between breathing a sigh of relief when he was wasn't stressing to feeling like he didn't need me anymore.*

When Daniel is having a good day, *I feel eternally grateful, on cloud nine*. *When we are having a good day, everything is positive, I think 'yes, I can do this, army life is not so bad, I can conqueror anything'. We get on so well* and we can have *good days at home or when he's miles away*; when *he rings* and sounds happy, *making a joke*. If Daniel's *happy, it's usually a good day,* and I feel like *I've done my job, like I've done something right, like I can tick a box. I get ultra-sensitive and lulled into thinking everything is ok*. *It can be ok for days, weeks even and then I just think, 'oh my god have I missed the signs, has this been brewing for ages, where's this come from?'*

It tends to *be moods* rather than *episodes* with Daniel and *it doesn't take much to start them off*. When the mood comes over him, *I feel gutted* because *it's easy for him to bring me down* and *if I am doing something good*, it can *make him worse*. I used to *feel helpless, I just wanted to help him, but I physically couldn't, I couldn't bandage it up because I didn't know what to do*. Whereas now, I know that *I have gone through these stages before I get moments where I feel frustrated* and I'm then *saying to myself 'here we go again' or 'man up'*. I know that *I can't be like that, I need to be supportive*, it's just *I get that turmoil of emotion but then I go into auto drive to calm the situation*. Daniel *responds well* to a *good talk down, he often says, 'oh I really needed that'* and I can tell *he's a bit calmer*. *The burst of anger can come out of nowhere and I'm like 'oh my god, like what the hell'* and *would do anything to keep him calm but now I'm a bit more detached*. *I sometimes wonder if I'm not doing him any good and that I made situations worse.* I used *to go quiet and let him get it out of his system, but I've toughened up over the years* and I think that *has helped, he respects me more*. *I don't think Daniel's anxiety and depression is any better than it was, I think our relationship is better and I think I deal with it better*. Over the last few years, I *wondered if what I was doing was helping him* and *I think I was because he's still here, he's not voiced any of the thoughts of like hurting himself anymore which to me is a good thing, but I think by not catering to it as much. I don't brush it under the carpet; we deal with it head on now.*

I think *I got absorbed in the army life*, and I *am trying to move away from that really*. *I don't really talk about it much but, at the same time, I feel like I've got to explain so friends don't think I'm ignoring them when he's home.* I think *army people get that, and some family get it, but other people don't. The past year has been like a seesaw; he's pushing but then I'm pushing back, we are not working together but then we are. I think we are probably the strongest we have ever been. It's been an individual journey and I've totally changed, I'm still a nice person, I still get Daniel the nice things, but I've started doing things for me too. I'm going away with the girls (friends from university), something I would have never done. I feel like I was before the army, and I had lost that but then I love Daniel more because he respects me more now. It's like a circle, I don't think Daniel will ever get out of it, it will be on-going and will carry him through life and I am always going to be frustrated but supportive.*

Lindy:

‘*I thought I bloody need a medal, there's absolutely no recognition at all’*

As part of my recruitment strategy, I contacted a number of organisations where there would be a strong presence of military partners. When visiting them, I presented a talk about my study. Lindy came forward following one of those talks. I met Lindy at her home. Interviewing Lindy was different to the first interview. Lindy struggled to open up about herself, there was an air of animosity and bitterness in the way she shared her story. Elements of Lindy's experiences were very similar to my own, whilst I was able to maintain composure during the interviews, transcribing them and spending time with the transcript triggered an emotional response in me (see discussion under section Reflective work, chapter 4).

In the beginning……..

Lindy and Craig *met during their days at university* and had *been married 30 years*. Looking back, Lindy felt the *writing was on the wall from the very beginning about what this life was going to be like with him,* she *had no idea, at the time and thought it was funny*. Craig *was doing P company (*Pre-Parachute training course*) when* they *were due to get married. Fortunately for* Lindy, *he fell into the wagon* (come off an event and into the safety vehicle due to injury) *on the Friday,* they *got married on Saturday and if he hadn't fallen into the wagon,* Craig *would have had to do a boxing competition so he probably would have arrived with a black eye and a broken nose.* They *then moved into army quarters on the Sunday and* Craig *went on* *exercise with the army on the Monday, and* Lindy *was left with £10.* When they first got married, Lindy was able to secure a job at the local hospital, *continuing with her career as a nurse and midwife,* moving jobs as they moved areas*. Four years into their marriage,* Lindy and Craig had their first child, followed by a second child two years later. *The children helped as they took some of* Lindy's *attention away from just the two of them*. She said, *I think if there was just the two of us, we probably would have killed each other.*

Over the years, Craig *completed a number of tours throughout his army career and was deployed all over the place, some being Iraq, Afghanistan and Sierra Leone*. He was also *part of a lot of special operations, which in some cases meant that* Lindy *was unable to know his whereabouts*. Married life meant that Lindy and Craig had *moved miles away from family, who never really understand the army life.* In addition, Lindy *and the children moved everywhere with Craig living in different quarters, they even moved quarters when Craig was away on tour until 2002, when they bought their home*.

Changing times……..

The *change* (symptoms of adjustment disorder*) was a gradual thing for* Craig, *an accumulation over the years.* Lindy thinks one of the first indications of change was when *their son was born prematurely*; *Craig went to work because he couldn't stand being there, seeing him.*

Craig completed multiple deployments; following each one, the symptoms became more apparent. Craig *had been a part of and seen a lot of trauma;* Craig and his team were fired upon in a *missile attack whilst in* Camp *Bastian* (Afghanistan*)*. Lindy never knew the extent of what he was *exposed to until months later when he came back*. Lindy felt, *there was never any acknowledgement* from Craig about the support she had given, *other than* she *had held the family together.* She *could remember having to shield the children a lot from all the media, it was relentless* whilst he was in Afghanistan. When Craig *was in Iraq*, Lindy's *mum was dying* and Craig, *at that point, was also feeling quite broken, so used his mothers-in-law's illness as a way back home*. Craig *returned home just before Christmas and* Lindy's *mum died early January*. On return, he spent the *time showing everyone photographs from the tour; they were quite traumatic and showed explicit images; it was like he did not know what was and was not appropriate*. Lindy *was furious, everyone was grieving*, and Craig *just wanted to look at these sorts of images. Over the years, within his cohort,* they *would see and compare who had the most* *traumatic picture; it is like he doesn't know when to cut off from it.* Lindy stated *that Craig* himself *said it had felt like porn.*

On *return from one tour*, Lindy said that Craig had *felt quite disappointed that she hadn't been there for him.* Lindy had *taken herself off for a walk because she couldn't be in the house when Craig returned*. To Lindy, *it had felt like he had returned with war on his clothes; for a few days after, Craig would almost sit in the dark, wouldn't eat with a knife and fork, struggling to adjust.* On another occasion, he came back from *one of the tours, like a king; he thought he was something, he was invincible, and it used to drive* Lindy *nuts.* She *would tell him to shut up, she wanted him to stop but it just didn't go away.*

On another tour, *he had saved a child's life*, the impact of this, Lindy believed may have been the trigger for Craig to *realise he had missed out on his own children growing up because he had been away so much*. Over the years, Craig *changed companies, moved jobs, booked events* - all of which meant *extra deployments*, *moving house* and an impact on *family occasions without any consultation with Lindy*.

Lindy describes the re-enactment behaviours displayed by Craig. Lindy *felt that in some ways, it's like Craig had a hunger for deployment; he was addicted to go into these danger zones but then he absolutely hated it and it drove him mad when he was there. He used to come back from them as if it has been a fantastic tour, he jollied it all up*. He had *come home before in the past, and just sit and watch war movies all the time, reading lots of war books, never a novel. In his work accommodation, it's like an icon to himself because all he had was photographs of himself in uniform; he goes to sleep with army t-shirts on, he wears them on holiday and has his baseball Afghanistan hat on holiday! It's like he needs an extra skin on, so he has to go to bed with these clothes on*. Lindy and *Craig own a picture painted by a war veteran with a brain injury, it's in Craig's office. It's a very moving picture of someone crawling across the ground in some poppies.* Lindy said that she *can't bear any of his shields and military stuff*. They have *kit everywhere in the house: in the attic, garage and then in another room as if he is waiting to deploy at any time; he could just get his kit and go.*

Over the years, Lindy said that *Craig always appeared to others that he is functioning very well, he keeps it quite hidden.* Craig *goes very inwards but develops this façade where he can be bright and chirpy, when around him, the walls will be falling*. But Lindy pointed out, *it's not real! It just doesn't feel real, it then* *makes the situations harder to read.* There *have been times throughout the marriage when Craig had extra marital affairs*, some with serious consequences. Lindy also believed Craig *is alcohol dependant to a degree because, the only time he doesn't drink is when he is on duty or when he is deployed. He doesn't drink constantly but he drinks two to three beers and glass of wine a night*. *When Craig comes home, and he says he's happy, he drinks even more*. He then *becomes even more shut down, more remote*. Overtime, Lindy believed Craig's behaviours of withdrawal and avoidance had become more notable; *he's become empty, he is not emotionally available.* Lindy's felt that *there is something else as well as the behaviour; it's something in their character too, that when combined, it all gets brought out together in a full-blown way.*

A few years after buying their own home, Craig was posted away; *he stays away all week, married and unaccompanied.* Lindy stayed at their family home. The *separation brought about further disruption and arguments*. Since the affairs Lindy and Craig *have been trying to sort of repair their relationship*. Lindy feels *there is a part of* her *that has put so much into the lifestyle that at times,* she *never wanted, that* she *feels* she *wants something back.* Things have *gone on for a long, long time*, and *children now that they are older* have found that *there have been times when they have not wanted to come home because of the atmosphere, they know when things aren't right and they just don't want to be a part of it.*

Lindy had *accessed individual therapy for a while*, *Craig tried therapy four years previously* to address his symptoms of adjustment disorder *but walked out after two sessions*. Three years ago, Lindy and Craig *accessed therapy together to try and sort things out.* When they went *to see the couple therapist, an analytic psychotherapist, she ended up talking Craig on but not Lindy*. Lindy was *absolutely devastated because it then felt like another rejection, it was a huge blow initially*. While they initially accessed couple therapy together, when Craig was identified for individual therapy, Lindy felt she was *kind of handing him over in a way and that it would be alright.* Lindy felt that this presented another opportunity to address Craig's PTSD symptoms. When Craig first started therapy, Lindy stated *he actually became quite good because he wanted to talk about it, he seemed to be the perfect patient*. Lindy knew *he shouldn't really be talking about it but then she also wanted to know what he'd been talking about in the sessions*. However, as time went by, Lindy noticed Craig had *become more closed off again and* Lindy *realised then that Craig wasn't using this the therapy, he was just pretending, lying about things*; Lindy *was angry*. He *started cancelling sessions at first,* he was *accommodated initially* *in the same way* Lindy *had always accommodated* Craig’s needs but then *the therapist ended the sessions*. As a last attempt at addressing Craig’s symptoms and the disruption it was causing within the marriage, Lindy and Craig accessed *a different couples therapy where* Lindy was able *to be present in the room at the same time.* Lindy felt that the *therapy had been quite disappointing really*. *The guy we saw was into war gaming and was always interested in Craig and what he does*. Lindy has *heard the stories so many times, there is nothing new from what she has heard, and all the while Craig seems to have become even more distant*. As part of the therapy, Lindy was asked *not to fill the gaps, something* she *had always done, done everything for him and accommodated him;* Lindy *was quite good at that*. *There are things that* they *both enjoy doing but* Lindy *was always quite happy to accommodate Craig*. Anytime Lindy *ever suggested anything Craig would suggest something else and then they would go off and do that because he couldn’t bear to do something that somebody else wants to do*. Lindy found that by not *filling the gaps*, *it opened up a bit more chaos because Craig didn’t stick to his word, he has never stuck to his word*. Lindy *doesn’t know whether it’s being the complete opposite of being so regimented in the army life that it’s all like a rebellion*. In *the last three years, it’s like Craig has disappeared even more, and the crisis point of him leaving the army for good has brought it to the fore*. *He was supposed to be leaving the army, it was supposed to happen last year, but he couldn’t go through with it*. *The army has kind of held him together and that has always been the way.* Lindy has *waited and waited for him to leave the army, it just hasn’t happened yet, leaving them in a complete mess*. Lindy stated *what Craig doesn’t know is there is life after uniform and there is*.

This is me……..Lindy

When we first got married, people knew I had just got married and moved; not one person would say ‘do you want to pop round for a coffee?’ Moving so far away from home, has always meant *it’s always been a bit isolating; felt like the outsider all the time, so I’ve had to cope on my own pretty much no real support from anyone. It’s been mostly lonely, it’s mostly been scary at times; having to go through those things of no news is good news and if anyone comes to your door, it’s going to be bad news.*

Even for work, in the years *just before we bought our house, there was a sense of almost if your address was on the camp, they wouldn’t want to give you a job because you were not going to be here for long. It’s all that thing about having to* *start all over again; you end up settling somewhere that is not home, you have to make a new home, but you never become quite part of the local community as well which is also really difficult.*

I have lived here since 2002, and I knew the choir had been set up, but I just couldn't bring myself to go because everyone knew what was going on with him and I felt so ashamed, that I couldn't connect with people really. Even in the village, people knew (about the extra marital affairs) *before I did. There's something about it, that thing what people are thinking of you and the kind of gossip that goes on; I would rather people say to me 'are you alright, how can I help you?' It was me that it (Craig's behaviours) was affecting*. At times, *I think it's been so awful*, but *it's as if people think 'oh well, you made your bed lie on it', so people/family aren't even interested anymore or they just get angry, that doesn't necessarily help either*. *I have fallen out with most of my family because they don't even ask how I am doing, and I am not going to tell them. I don't even know what would help. Even if welfare had come, I would probably say I was fine as there would be an expectation to cope. I think I probably in some ways would have liked a channel, when I was on my knees perhaps to say, 'I need help,' but then I would have had to disclose what was going on, but they would say that's just a relationship thing, it's nothing to do with the adjustment, but it is*. *I once ended up buying a blouse on with all these medals on because I thought 'I bloody need a medal, there's absolutely no recognition at all.*

I've been very, very, angry for years over lots of things. When my mum died, I felt Craig could have been there for me, at least for that; I was angry, he used it as an excuse to get back for the army needs rather than me. There was a time I found out about the affair, he'd come home on R&R and he went back. I have been ill at times, got quite serious asthma, but in his eyes I'm never ill enough for him to come home; there's nothing for me but if the army says jump, he'll say how high and off he goes, that's what makes me furious. I would say I am with this empty shell, and I have become more of an empty shell because of it. I don't want to be in relationships with people and I have become quite resentful over the years.

I have mixed feelings about arriving at my 30th wedding anniversary, 'cos it doesn't feel like it's been a marriage. He has pushed me and done stuff to make me angry in a way I have never been angry with anybody else. There's a real stubbornness I think to it, I can be very ungrateful or spoil it. I try not to but the level of resentment I have just comes out all the time.

It's a lot though, 30 years of army life and I suppose most people only have about five before they say enough is enough, I don't know whether I use the trauma of the army as a reason to stay because if I had just been an ordinary civvy life, I wouldn't have put up with it. As well, there is something in that we grew up in the same area and during troubled times, we sort of cling together. As we have been trying to work through it, it's been hugely painful for me, I've not had anybody to turn to, so it's been an absolute mess really. I just don't have the energy to start all over again. At the minute it feels like I'm banging my head against a brick wall, and I have, I think the biggest hit for me was why he couldn't do the seven clicks (the process to complete to leave the army)*, and we have talked about it for years and years, he didn't want to stay for too long and become burnt out. But then he never really talked about it, I kept pushing him about a plan and through the therapy for the first time ever in my life I ended up giving him an ultimatum and saying he needed to do it and if we didn't, we would split up, some bloody ultimatum. He tried to do it and couldn't, I was absolutely furious said that he couldn't come home but now I look at it and* believe *he is so institutionalised.*

But at the same time, I often say if anything ever happened to him now, I wouldn't even grieve because it's like being a widow almost really, in a way I have been on my own for such a long time, I don't know whether I can adjust now if he does come home. It's an interesting thing, adjustment disorder, because I suppose in order to survive it, I have had to adjust quickly all of the time and I have become quite good at that. But I think *he doesn't know how to adjust.*

Simone:

'It is hard work, you can only do so much for them, it's not easy at all'

Simone's husband and my own worked together at the same camp. Simone learnt about this study from one of the postcards left with the community development worker. Prior to the interview, Simone and I had never met, and we had only spoken by phone to share the study documents and arrange venue and times for meeting. The interviews were held in Simone's home. We sat in the front room with a cup of tea, surrounded by Simone's dogs and cats. At the beginning of the first interview, Simone seemed nervous; shared that she was a little worried she would it get wrong; reassurance was given, and I explained that there was '*no right and wrong*', it was simply about telling her story as she had experienced it.

In the beginning……..

Simone and James *knew each other in primary school* but *didn't really speak to each other until years later*. *They had been talking a while and realised they were attending the same funeral. They met at the funeral and started seeing each other*. James was *already in the Army*, *had already completed a tour in Iraq, had recently returned from Afghanistan and was serving in Germany at the time*. James went *back and forth to Germany, travelling back to the visit* Simone *until he received a posting back to England*. Simone and James *married really quickly*, *seven months after* meeting each other.

James was posted to the South of England, where Simone *joined him in married quarters, living on camp.* During their time in the South of England, Simone *ran the salon on camp, working as a hairdresser so would hear a lot of the gossip around camp*. Simone got to *know everything that went on, so chose only to have a couple of friends*. James was *deployed to Jordan along with the neighbours' husbands*. Simone was good friends with the neighbours, *so it was great when they went away, the wives did everything together, had tea every night together* and so on. These friendships continued, despite different postings and *it is really hard to catch up and time passes*.

Another of Simone's friends Sally, moved around quite a lot. Simone *used to babysit for them,* but James *would never go with her because Sally's husband was an officer*. James and *Sally's husband didn't even work on the same camp, the camps where more nine miles apart; he was funny like that.*

James was then posted to Northern England. Following the *move into army accommodation,* Simone *didn't really know anyone* but continued to *work as a hairdresser*. Simone *tended to work a lot or travel to her hometown as it was only about an hour away from camp.*

Changing times……..

Simone *recalled that things massively changed* in Northern England; James had sustained a *knee injury*. Shortly *after moving*, James *was deployed to Sierra Leone during the Ebola crisis*. Since then, Simone and James *have been through a lot*. According to James's *Nanna, Sierra Leone was the change*. Although the deployment was humanitarian and not into a war zone, James *saw things there that were worse than any where he had gone before;* Simone *said that it is the only deployment he ever brings up.* Simone stated that James has since shared *that whilst they were driving down the road, there would be someone hung there or there would be a kid on the road.*

Returning from Sierra Leone was *when things spiralled but, at the time,* Simone *said that it was hard to know whether this was a result of the posting* to Northern England, Sierra Leone or James's knee injury. From Simone's perspective, James *started drinking more, he was getting angrier and had a temper*. During his time in Northern England, James *was diagnosed with depression*. The *army doctor had thought the depression was related to the knee injury*, but Simone *thought it was a mixture of all sorts*. James was referred for psychiatric treatment and physiotherapy whilst serving, *this was away from camp* and James *attended alone*. James had said that *he was only ever given medication to take and there wasn't really any other treatment available*. This annoyed Simone as she believed that *medicine is not the answer for everything and that really tablets were not the answer*. James *didn't see anyone to talk about it, get out what he wanted to get out, which then obviously built up. James is a very open person about anything, but he never opened up about what he should have spoken about.*

Day-to-day it wasn't too bad; on a morning, James would be fine but then when he came home at night there would be no conversation, and he would drink every night, this was not normally what he did. On *really bad days, James won't get up, won't do anything and didn't want to do anything not even a conversation*. Simone thought it might help to *move out of army quarters and buy their own home*, she *thought things would get better*. It didn't really help, when *they lived near camp James was always at work but then when they moved, he hated it, he didn't want to be back to work.* During the bad times in Northern England, if Simone knew James had an appointment, she *gave him ultimatums saying she would speak to someone, to make sure he went. It was worrying that he was really suffering, and no-one was helping*. James did *end up sorting it himself* cos he knew it had got to a point where Simone had *literally had enough*.

If they were having a bad time, *often after work,* Simone would seek *support from her dad which always made her feel a little bit better and able to deal with it*, she *could cope then.* Simone's dad and James were close but, whilst *in the army, he never spoke about any of his experiences.* Back from Sierra Leone, James *couldn't sleep without the tele' on and he would still wake up,* would *shoot up* (jump up out of bed) *and stuff during the night but* Simone *managed to get him out of the tele thing 'cos* she *just couldn't sleep with it on.* James *would wake up thinking he was still in Sierra Leone.* Over the years, Simone *had managed to remove any TV from the bedroom*. For *James to cope with this, he would 'zone out' by being on his phone playing games most of the evenin*g.

During *the last eighteen months* of service, James *went through his real bad stage*, where *he had more bad days than good days*. Just over a year since buying their own home, James had periods *of sick leave* and was eventually *medically discharged from the army*. He *was medically discharged due to his depression and knee injury with nothing, no support.* Simone believed that *James wouldn't have* left the army, *even if the choice had been his*.

Once James was discharged, there *was no real follow-up or hand over into civilian NHS care;* James had to go through it all again. Simone recalled that Jame's *symptoms didn't change once he left the army; he was still angry, but it was becoming more and more*. In the Christmas prior to the interview, Simone *had left the* family *home* because of the state James was in; *he had punched a hole in the wall; he had never done anything like that before, and he kept having these sorts of outbursts.* Whilst Simone *was gone, James attempted to take his own life*.

The hospital had contacted Simone, who initially *didn't want to go back*, *the doctor explained that James would be a higher risk if he went back alone.* Simone *went back home* with James. James was then under the care of a psychiatrist, with a *possible diagnosis of PTSD* being explored. Simone had *been invited to be involved with his treatment and* James had *started opening up a little bit more, talking about it where he never had before*. During recovery, James had shown Simone *a video, he asked her to watch it. It was of this guy; eventually, this guy did kill himself because he couldn't cope anymore, his family didn't understand him, his wife left him 'cos she couldn't understand what he was going through and, in the end, left him 'cos she couldn't cope anymore.* James had said *that's how he felt, unable to speak about it, he had to do it through a video* to show Simone. *This year is the first time James has ever spoke about it*. Leading up to this point, whenever Simone had tried to talk about James's behaviour or what he had experienced on deployment, James replied *'I don't talk about that'. The whole time they have been together, James's never spoke about any of it. He just thought nobody does; it isn't talked about at work, so you just don't talk about it.*

This is me……..Simone

I don't like the army; it has definitely messed him up really. I wasn't really a fan of it anyway to be honest. I didn't really like living in army quarters, they all say they are family orientated but they are not. I don't think they think anything about families, it's all about the soldier. Moving into our first quarter in the south, was exactly how I imagined it would be like; I remember saying to James, 'I don't really want to be *like to involved with it all'. It was horrendous. I worked in the hairdressers on camp, and they all used to tell me everything, I used to find out all the gossip. It was great, I used to tell James everything.* When we moved to Northern England *it was quite lonely, I lived on the estate not in the camp and I only knew a couple of people, two civilian friends and a couple who were military. I still did hair; I knew a few people, but it was clicky and people with kids. We haven't got kids.*

At first, I just thought James was fine and never really noticed anything, *it was his nanna* who first noticed the change in James. *When I think about it now, for me, it was James coming back from Sierra Leone*. Although, *I don't think it was probably up until the point of him being discharged that it really hit me. I just started noticing things, he was drinking more, and when he had had a drink, he was getting angrier and had a temper. There was quite a lot of arguments.*

I'm quite a positive person, and always *suggesting things to do or places to go*. On a good day, *we get on really well and we will go do something* and *I always think great, nice one. We will have a good day when he's having a good day*. On a bad day, *James will just say 'no, just sit there' and I can't cope with this. Straight away I'm in a mood because I think this is what the day's going be like. I can't get him up, I can't get him to talk, so I get quite irritated and then it ends up in an argument generally*. *More than anything, it is really frustrating; I get annoyed and go on a bit of a downer. I would dread the rest of the day. Sometimes I would just look forward to going to work to get out away from him but then I hated the thought of coming back again because how he is. I started to feel really down and started to think I was getting depression. I would ring my mum or dad for a moan, and dad would say 'you are going down as well as him, he's bringing you down being like that'. I'll say something positive, and he will always find the negative in it, I just think oh god, its hard work. I have thought I don't want to have to deal with this every day, this isn't the life I chose.*

I haven't got a clue how to deal with it, I don't understand it. In the beginning, I just thought he was being like that, just being an arse. I would say to James 'you need to do this, you need to do that, you need to go tell them at work' because I didn't know what I needed to do or who could help. I used to threaten coming into work with him, but I didn't know what I was doing really, but he didn't know that. Thinking about it, I would have got in touch with one of his friends if I ever needed anything, but really, I wasn't involved in any of it. Now I'm a little bit more accepting, so if he is having a bad day, I understand he's having a bad day, even though it makes me *have a bad day. I just think I will just go do something, I get out the way, I do try to pick him up by encouraging him, saying 'come on we'll go out, you can't just sit there on your phone all day that's just not how it works'.*

I wasn't even here when it happened at Christmas, *I didn't know what he had done* and then *the doctor was ringing me from the hospital telling what had happened. I made the decision that I wasn't going back, the doctor asked me to consider it. I then thought about if he went back home to an empty house, with more tablets and alcohol, and said I would, but the doctor would need to speak to him too. James has now started to open up a little bit, I watched a film he shared with me and it was really upsetting for me watching it.*

The bad days don't really go onto next day anymore and the past couple of months haven't been too bad; he's having more good days. Now James is out of the army, and *we are both working, it's just hard; hard to get anywhere now because he's having to go for appointments to* the mental health team*. I would love to go with him, but he has to go to so many appointments or the waiting times are so long it makes it hard for me.*

Lauren:

'*I say this from my heart, I don't think he would do it* (take his own life), *but I would hate it, the fact of I missed a sign because I would never forgive myself'*

Lauren was a friend of one of my earlier participants. Before our meetings, we had made contact over the phone. I met Lauren at home with her two small children, where she was busy packing to move home. Lauren shared her story openly and apparently with ease.

In the beginning……..

Lauren and Damien *met online* at the end of *2008 when Lauren was 16 and Damien was 17*. They *talked for a while on MSN* and then decided to meet. Lauren and Damien lived nearly 300 miles apart, Damien had recently joined the army. Lauren *decided she fancied a trip north*, she used to live 20 miles from the town Damien lived in, *so took a train to meet him*. She had *lied to her mum and dad, saying she had known him for ages*. Despite being *as scared as anything,* Lauren travelled by train to *meet Damien at his local train station*. She *saw him straight away, but he looked a lot older*, she *checked his ID before leaving the train station* with him. They had *walked in the rain for miles* to get to Damien's leaving Lauren *unimpressed with* *it all,* but she *was stuck there for the weekend.* Lauren stayed at Damien's parents' house where she *met several of Damien's family*. Lauren *was embarrassed,* as it had never meant to be anything serious *just a bit of fun*. The weekend went fine, Lauren returned home, and they *continued to stay in touch*.

Damien was then posted to a new army camp away from his home, which meant that *he was closer to* Lauren, with *an easy commute* to see her. The *relationship then became really serious and quite intense quite quickly*. Damien *proposed to* Lauren in 2010; *he left a ring on* Lauren's *side of the bedroom;* Lauren said *he was too nervous to ask*. Lauren the *sent a text* asking, '*what the hell is this ring?'* Damien replied, '*oh I just wanted to know if you would marry me'*. Lauren *said yes.*

Lauren and Damien *got engaged;* however, Lauren said Damien's *mum hated the idea* believing that they *were too young*. They were 17 and 18, *it caused a lot of arguments between them;* Damien retracted his proposal, Lauren *said 'you can't propose and then take it back 'cos your mum's not happy'*. In the end, *they separated*. After a while, Lauren and Damien *were back together*, with a plan to be married once again. Damien was then deployed to Kenya, on his return in *October 2011,* Damien *said 'you know I'm very serious about getting married, let's get married in January'*. They *were married in 2012;* they *had a lovely day* and Lauren felt the situation between her and Damien's mum improved.

Lauren and Damien *moved from private rented to army accommodation* a few months after the wedding, starting a family was the next step. *Damien was very sociable*; their *house soon became busy,* and Lauren *found herself cooking meals and so on for not just Damien but a lot of his mates from camp*. Lauren *loved it; the house had the best atmosphere*. Most of Damien's *mates were single so Lauren never really knew any army wives*, she was *very reserved about getting involved with the wives until one moved in and they just clicked*. *Between 2012 and 2015,* Lauren and Damien had a lot of *stresses trying to conceive* and *a lot of fertility problems*, but in the end, *concluded that they weren't going to have children*. Damien's job had been demanding in that he was constantly away for six months then home for two as it was such a busy unit. After two years, Damien was promoted and with this came a posting which meant a move for Lauren and him. The posting was changed but a move was inevitable. They *started to enjoy life at the new posting*, surrounding themselves with *four dogs and a cat*. *Four months after they had bought the fourth dog,* Lauren *found out she was pregnant*; Lauren *was really* *chuffed*, although she said Damien was *worried about it financially*. It was during this pregnancy that Damien sustained an injury to his leg.

When *Ethan was born at the end of 2015*, Damien was *able to be present at the birth and take holidays* as his posting was a lot quieter than before. Despite this, Lauren started to notice a change in Damien; *he seemed unhappy* and *fed up of the army*. At the time, Damien was *receiving physiotherapy for his injury;* the physiotherapist was very encouraging *saying they could fix it if Damien continued with the therapy*. Damien attended physio and Lauren thought he was *positive* about a resolve to the injury. Ethan *was six months old when Lauren found out she was pregnant with Chloe*. Lauren felt Damien *was the opposite of how he reacted with Ethan; he was positive* about the news, but she was less enthused and *struggled to acknowledge the pregnancy for some time*. *When Chloe was born, Damien was still attending physiotherapy for his injury;* however, *there had been no real improvement*. Lauren said *after five MRI scans,* the source of the *injury was identified,* and *surgery was required, done five months later.* Lauren felt that *he remained positive, despite being told that there was a chance that the surgery might not fix the injury completely*.

Changing times……..

Following the operation, Damien had *his cast removed*, *then his moon boot thing removed, and returned to work*. During his recuperation, Damien had not attended work or physiotherapy. On returning to work, Damien's *leg and ankle were still swollen*, his recovery was delayed, and he was unable to complete the requirements of his job such as *wearing his work boots and taking part in drill*. Lauren said Damien thought that this caused a lot of friction between him and his bosses and *left him feeling victimised.* During Damien's sick leave, he *had not attended physiotherapy which had been an oversight as he hadn't realised, he had to attend*. When this was addressed *by his bosses, Damien left the office in tears*. It was at this point; Lauren noticed a change; signs of Damien's depression surfaced. Damien *attended his physiotherapy appointments, cancelling his summer holiday* to attend. Lauren believed the friction within the workplace continued, and that Damien continued to feel victimised by both the army medical team and his chain of command. W*ithin two weeks* (of his meeting with his chain of command) *he was removed* from his current role *to one in another department*. In his new role, Damien had *acquaintances that he probably won't speak to again;* he's no longer sociable and he *hasn't got a group of friends*. Damien *isn't really the sort of* *person to sit there and say how he feels anyway, he'd rather just lock it away* that is *until he has a really bad day*. Lauren feels that Daniel takes this out on her; he *can then be very vocal with his emotions.*

Lauren felt *there's a lot of pressure on the relationship;* she is *at home with the children Monday to Friday, whilst Damien is at work and then Damien takes over at the weekend whilst* Lauren *is at work*. They *argue over the littlest things and if Damien wakes up in a mood, it gradually worsens throughout the day.*

During the surgical review, Damien was advised that the operation had gone well but, because of the *ongoing pain* he was experiencing, a further *diagnosis of arthritis* was given with the *likelihood of the pain eventually getting worse*. Damien *struggled to walk for any length of time* and found *running very difficult*.

Damien was then *prescribed strong pain killers to manage the pain*, he *saw the doctors quite regularly* and his mood began to decline. Later, as a result of *the mistrust of his camp medical services,* Damien accessed *another army medical service on a different camp.* At this point, Damien was *diagnosed with depression, scoring quite high on the scale* and a *medical discharge* was initiated. Damien *became quite withdrawn;* he *saw a mental health nurse, on a regular basis and they talked but, because he didn't have any like childhood trauma or any other traumatic event, it was the situation that was making him depressed rather than another reason*. Lauren said that it was reaffirmed by the doctors that *he would be fine once it was all sorted.*

Lauren admitted that she was *quite naïve about it all* (Damien's behaviours) *at first, thinking 'oh he's just having a bad day', until one day in December, when Damien rang from work in tears crying, 'I've had enough of this, I can't do it anymore' and then hung up.* Lauren rang Damien back; he had argued with his bosses and walked out of work. Without Damien's knowledge, Lauren *telephoned army welfare as it had now got to the point where I was struggling to cope*. Lauren had become increasingly *concerned* that something was going to happen and felt *she didn't think he was going to end his life but, with mental health problems,* she *just wasn't sure*. She voiced that she was *really concerned about her husband*, and that he had become *really withdrawn and vacant* which was out of character for him. She was advised to 'get him to the doctors' but, since Damien had felt victimised by the army medical services, she knew this would be difficult. Lauren reiterated he needed support at that point, *she explained* to army welfare *about the phone call and that he had failed to return home*. She *threatened to come on camp to look for him*, so welfare escalated the incident up the chain of command and an emergency doctor's appointment was made for Damien.

Lauren was *able to attend the doctor's appointment with Damien* and used the opportunity to *speak out to say how vacant Damien had become,* explaining how he was behaving. During the doctor's appointment, Damien's medication was reviewed and, in light of his strong painkillers, prescribing antidepressants alongside them was not advised. A different analgesia (also used to help with anxiety) was prescribed, along with the offer of counselling, although Lauren believed there was scepticism from the doctor over whether it would work since they believed the depression was situational rather than caused by a trauma. Lauren was disheartened by the consultation; Damien *received a two-week sick note and then a further four weeks sick after that*.

Lauren felt that Damien started to *pick himself up a bit especially with the family because he wasn't at work, he started to look at things more positively*. He returned to work, but, after *one-week,* Damien had deteriorated. Lauren said that he felt there was *no-one for support or looking out for him*. His role meant that he sat in an office with little to do, which wasn't *good for* his mental health. Damien was allocated a *key worker to link with* for his *medical discharge*. Lauren stated that in November he had been told that his medical discharge would be pushed through quickly, but that it was now February, and he hadn't heard anything. *The pain was bad*, and *he was at the doctor's three times a week*. Damien became increasingly *fixated and worried that he was ill or had symptoms of something* (he did not know what)*; needing reassurance that it wasn't something serious.* There were further delays to Damien's medical discharge and *in total it took nearly a year to complete*. Eventually, t*he army told Damien he was officially discharged, whilst there has been a lot of stress, there is the feeling of relief*. Lauren felt that *the army don't really care what happens, the soldiers are just a number* which is why she is *glad to be getting out of it*.

This is me……..Lauren

When I first become an army wife, I was so positive, I thought this is a great life. I was really naïve, the atmosphere was great but when something tough comes along, it's actually not that great. It's just draining; I'm quite a positive person but it even got to me, and I thought 'this is hell, like hell on earth'.

It's so much stress for me personally, no one *takes into consideration how I was feeling, how it is to live with someone like that. He's not the man I married, it's awful.*

As much as I love him and I want to support him through everything, I still have two children and their welfares to think about. It's not that I think he would hurt them; more that when he is withdrawn, what if the children hurt themselves and he doesn't realise? I have to go to work with a fear of leaving them because what if one day, he just thinks he's had enough things and goes off to do something? I don't know how mental health affects people. It *causes me stress* because *I work ten-hour shifts and I think bloody hell, I listen to mental health stuff all day and it does drain me*. Even if the army welfare would *just say 'we know your husband going through stuff and we just wanted to make sure you are ok* and *have a cup of tea', because then I could say actually no, I'm not ok, I'm going to leave him'*. *They think every lad is single, they don't take families into consideration*. *They don't see how it affects him when he's at home; how much of an impact it has when daddy is sad*. *It makes* the kids *play up* and *then it's up to me to pick up the pieces and I have more work trying not to aggravate the situation, then if we all lose our patience we just go around in a circle*. *You have friends to vent to, but you can't to the real extent because you don't want them thinking everything is rocky at home, you want everything to seem ok. It's the same with family, you don't want to tell them the true extent of it because otherwise everyone judges.*

I've got friends here; I see them every now and then but it's very difficult because most of my friends work Monday to Friday and I work Saturday and Sunday, so I don't see anybody really. My *friends have said to be careful it doesn't get me down*, whilst *I am a strong person, it has still really challenged me*, and *I have probably said things that aren't the best thing to say to someone through this.* Damien *used to follow me around to the point where I would just snap 'seriously get out of my way or I'll do something that I am going to regret, you are getting on my last nerve'.* At one point *I just said, 'me, and the kids are going until you sort yourself out'. I was like I can't do this; I can't do it'.* It can *put me in a mood, and I don't like it. It does pull me down a lot, I've not got the patience and I would rather go out, clear my head and be my normal person again*. *It's just such a different environment with him being in a mood. It happens quite regularly actually.* Although he has *never declared he's thinking of suicide or declared that he wants to self-harm, how do I know what to look out for if he's going to kill himself? I say this from my heart, I don't think he would do it, but I would hate the fact of I missed a sign because I would never forgive myself. I would hate myself thinking that I had missed a sign, you know it's hard.*

This is the thing; I don't understand it enough to understand why he is in a mood. He is sometimes *in a mood over nothing,* and *I don't understand it, if I'm in a mood it must be about something*. *I tell him to stop taking out on me and the kids, I tell him he's been really horrible, it probably doesn't help the situation but it's how I feel. I don't understand mental health in a sense of why he would act like that*. I just think '*oh he obviously doesn't like me, he must not like living with me' or 'I don't know what I have done wrong, I'm the bad one and I'm obviously the person that is tipping him over the edge', then when he comes out of them, he explains to me that he can't explain why.*

Damien *fixates on illness and symptoms*, he's fixated *but it doesn't just affect him, there's been times that he has called my work with chest pain; he's had an ambulance sent out and I've had to come home. We've gone to A&E; they have done ECGs and everything was fine. It takes hours and I have to leave my shift to look after the kids. I don't want to be that person who is always running home because their husbands going to hospital with another anxiety attack or something. It's just frustrating, it's the day ruined* and then he gets to feel *he's ruined my day and then it just goes into a vicious circle,* and *he can't pick himself up.*

Harry:

> *'This is what you are like.....I'd tell Nicole every time when she was laughing, or she found something funny or was spontaneous or do something silly. I would always say that is, was nice to see her like this and just remind Nicole or just say well actually 'this is what you are like!'*

Harry contacted me after his wife picked up one of the postcards, I left following a talk with one of the external military spouse organisations. He emailed me and an interview was arranged. The interview took place at Harry's house, and I was greeted by their two dogs. We sat in the front room, which was bright and homely, surrounded by children's toys and family photographs. Harry's wife Nicole had recently deployed to Omar on a four-month tour. Both children, Samuel aged 6 and Rosie aged 2.5 were at school and day nursery. Harry shared his story confidently, very matter of fact and was less emotive than the others interviewed (see chapter 4 for discussion on gender differences in interviews).

In the beginning……..

Harry and Nicole *met at university* in the Northwest of England. Nicole had been with the military *since 2003;* she took a *gap year after university* and then *commissioned in regular service;* Harry *commissioned as a reservist* but has since left the army. After finishing university, Harry and Nicole *lived together for a while*. *Before they were married, both* Harry and Nicole *went on tour in Iraq*. Nicole then took a posting to Northern England where they lived in army accommodation. Nicole then completed *a winter tour of Afghanistan; she did the Christmas and finished in the January,* because of her job, *she only does 3-4 months.* Nicole *got those two tours out the way before, before kids*. The *following November*, Harry and Nicole had *their first child, Samuel*. Nicole completed *a three-month exercise when Samuel was two years old.* This was the first time away from home for Nicole since Samuel had been born. Harry and Nicole communicated through *Skype then and that worked*. Harry felt that they were *quite lucky* because *Nicole was away when Samuel didn't actually know anything about it. It's only really been four tours which is thirteen months away in nine years which is pretty good*. They had a *second child, Rosie, following Nicole's three-month exercise* and Harry recalled *that everything was fine.*

Changing times……..

The biggest issue for Nicole was post-natal depression following the birth of Rosie; but *it sort of built-up.* Nicole *had it before Rosie was nine months and it extended to about 15 months in the end*. It *was Nicole's decision to see someone*, Harry said that he *didn't push it*. *It was lots of little things and not doing things.* Nicole *did try and hide where she is just crying and where she breaks down, but it was, just was where no-one is around, which is fair enough for the kids.* Nicole was *never aggressive and couldn't even give you a trigger of what started it.* Nicole was *thinking all the time and then would find herself in a ball and crying and couldn't really work out why*. Harry *found Nicole like this twice.* Other than these two occasions, Harry described how Nicole *had pushed back on everything and hidden it*. Nicole's *sleep was pretty bad, and she would do a lot of thinking or reflecting when lying in bed. The shower was also another place* where Nicole *would come out either really upset or really happy and* Harry *would wonder why.* Harry stated that Nicole would always respond *'I'm fine' when he asked her how she was feeling.*

Post-natal depression *was the longest bit and the hardest bit* for Harry and Nicole; *the maternity leave was coming to an end* and Nicole, Harry felt, *realised* that *she wasn't going to be able to function back at work*. It was these two occasions and the *build-up of going back to work* that Harry thought was the trigger for seeking help and Nicole finally went to see somebody. *It was handled very well because Nicole knew the doctors, but Nicole chose to visit one who she did not work with and who was sort of out of the loop of people she knew.* The counsellor was also based away from Nicole's workplace. During counselling, Nicole said they *would always ask if she had had thoughts about ending her own life* and Nicole *did but never really had a plan or a whatever; it's just sometimes* Nicole *would just lie there crying for no reason, thinking she was a burden.*

Nicole's *maternity leave rolled into medical leave*. Nicole *went through the whole system; she was prescribed anti-depressants which made Nicole non-deployable* status *for six months which progressed to a year. You have to be off them* (anti-depressants) for *six months before the army will upgrade you* (return status to deployable duties). During this time, Harry and Nicole *were at home together, there was no work for Nicole because she was off anyway so there wasn't an impact really*. Nicole *didn't have to drop work as such so it didn't really start adding up and changing to being rubbish, thinking the works not going well or you're not doing your bit.*

As Nicole was *moving to come off the pills, Nicole's mum was diagnosed with cancer and died within a few months and that's when* Harry felt *it kind of snowballed*. Harry said that Nicole was *advised to stay on the pills a bit longer as this was probably not a good time to sort of come off*. Nicole had *been through the whole system, the meds and then the counselling which lasted quite a long time which was good and really helped*.

After about two years, Nicole started to come off the meds and started to return to work. It was a *gradual return back to work*; Nicole *came off the pills really well and it was alright really*. Up until this point, Nicole had not told anyone at her workplace about her post-natal depression, then she told *somebody in the regiment why she was off; she felt she had to and wanted to.* Harry *thought it was a good idea as it meant that they were a bit aware*. There were a *handful of occasions where Nicole did just say 'I've got to go home', because hers is really doing an office job; Nicole is a training officer but does two days clinical and you can cancel those, it's annoying for other people but it meant Nicole could work from home.* After losing her mum, Nicole's relationship with her dad became difficult and pretty strained; Nicole *doesn't really speak to him now*. *Every waking thought was how to deal with dad.* Nicole and Harry *found themselves talking about him all the time*. *It drove*

Nicole nuts; it was just constant anxiety on how to deal with it. There's kind of been an incredible kind of run of events over the last two years. Nicole has had a really shit run but she's still got a good circle of friends, two or three friends all the way back from school, that are like family she has grown up with so that's been quite good and there is an aunt involved, who's been really useful.

Nicole still has *some anxiety today, but they don't really diagnose it, it's just that is massively there. Even things like gearing up to ring her dad or sister would trigger times just thinking or Nicole would have a physiological response*. *It is better than it was a year ago*, if Nicole was on the phone *she would literally be shaking and just couldn't speak sometimes. All of that has slowly got better.* Harry said that *looking back, Nicole can't really remember much of Rosie being a small baby and it had all been a series or catalogue of events. Nicole has been through it now and kind of happy now.* Nicole is currently on tour, she had a *little bit of anxiety before going away this time*, *but it wasn't anything like going back to that, just a normal mam thing about being away from the family*. On this tour, they have Wi-Fi and Harry, Nicole and the children have *spoken on the phone and done facetime.* Harry felt that now Nicole was away, she would be fine; *she'll just keep herself busy* and he believed she knew that he *can handle everything at home*.

This is me……..Harry

During Nicole's army career *we've done all right; she's only had 13 months away in nine years, so we have had it pretty good, it's been fine.*

The whole period with post-natal depression is really odd, neither of us can kind of remember a lot of what went on. It's just amazing how quickly you blank the day-to-day stuff out. In the beginning, I just had my sensible head on and didn't really push it because we were both off work anyway. I'm a science teacher and understand medically what's going on and that is half the thing. It was just trying to get her to talk to somebody. It actually doesn't affect you and I don't know why but I've been alright. It's just as long as everybody is fed and watered and warm and happy, it's alright. I can generally be quite an optimistic person, quite relatively sensible and don't do anything silly, it gives Nicole time to work out what she wants. There is stuff happening at home but everything else carries on as normal.

I'd tell Nicole every time when she was laughing, or she found something funny or was spontaneous or do something silly. I would always say that is, was nice to see her like this and just remind Nicole or just say well actually 'this is what you are like'. There were days when you get in a good space and it's just really nice, takes you *back to what Nicole was like and things like that. Telling Nicole of the good things that were happening helped her take it in right away, but then there was always a bit of reflection, and it highlights that there's something not right.*

After the summer break, I went back to work as normal and the day-to-day grinds on. I would come back from work, and everybody's been fed, and everybody's had a nap, but it would be when Rosie was napping that Nicole would be feeling rubbish and I didn't see that. I think it did have an effect at work; I didn't miss anything or had any issues at work, it's just all the time you are thinking about when you get home, 'what am I going home to?' There was a long time, where coming home every day, even though I was getting away as quick as I can, I didn't know what I was coming back to. I didn't know whether Nicole had made dinner or whether I've then got to come in and do it, or if I walk in and Nicole is just giving me Rosie and saying 'here, I'm done'. Or come in and she will be fine and then just break down 'cos I'm home and she can just let go. It did play on my mind all the time at work; thinking about it all was the real issue or getting a text that you don't know what it is about, and you can't do anything about it until you get home. I've been the one keeping it together, I have been doing most of it but there has never been a time where Nicole couldn't pick her kid up or could have cooked dinner so there has never been sort of a big impact.

The biggest one is, it's frustrating because you don't know what has triggered it and that's the hardest bit. The hardest bit has been trying to catch what has started Nicole getting cross or upset; when you really can't work out why, it's just that frustration of not knowing. Even when Nicole started counselling, they don't know and she doesn't know, it can just be she has just thought of something or looked at a situation or she's seen the kids really happy, and it sort of triggers something.

Once the counselling started it was fine, *I just had to arrange and make sure I was here because it could take anywhere from half an hour to a couple of hours. It was all very different; before the counselling I would wonder why Nicole was upset, she would say she's fine and we would leave it and then half the time she would come and say what it was, but it was always much later. Once she started getting help, Nicole would show me or talk about things she was trying or things the counsellor had said. Nicole would carry on the discussion with me, we did a lot more talking. Once Nicole had the realisation of that in the first place, she kept me involved.*

Cathy:

> *'This is so sad that for all these years our marriage has been tainted with this issue and actually it's only now that we are the happiest, we have ever been'*

Cathy was a friend of a friend of one of my earlier participants. Prior to the interview, Cathy and I had only talked over the phone. The interviews were held in Cathy's home. We sat in the front room with Cathy's dog. Cathy openly shared her story but started by saying I agreed to do this because *'you are one of us, you get it, thank you for doing this because it's important'* (see chapter 4).

In the beginning……..

Cathy *met Adrian in his hometown*. After they got together, the relationship *moved quite quickly.* Cathy *was 27 when they met,* seven years older that Adrian. Cathy *knew Adrian was in the army when they met* and very soon in the relationship, *Adrian was posted to Norway*. At first, Cathy *waited; but, after a while she just thought, 'do you know what, what am I doing, I'm nearly 30, I'm wasting my life here waiting for someone to bloody come home all the time', so she dumped him*. Cathy said *Adrian was devastated; he was really upset,* and Cathy wasn't really sure so, on his return, *sorted it all out* – they were together once more. Cathy was *working in a really good job, so they decided to buy a house* locally. Adrian *lived in camp through week* and returned *home on weekends*. Whilst they had *no children things were alright, they worked all week and had amazing weekends*. Adrian was *bomb disposal* and completed *a tour in Iraq*. On returning from Iraq, there was *an incident when Adrian was laid on the couch and the door slammed, he hit the deck and scrambled to the floor*. Cathy *accepted this* behaviour because she *thought 'well that must be just something that triggers because obviously he's heard it for six months'.*

In the time following Adrian's return, Cathy *miscarried several times; he never cried, he never showed any emotion*. At the time, Cathy didn't pay much attention to this and believed it was because of *something from the army*, that *from such a young age its drilled into them not to show any form of emotion whatsoever*. Cathy then became pregnant and when the pregnancy progressed, Cathy *knew a decision needed to be made,* about *whether she brought the child up on her own with Adrian home on a weekend or to leave her job and follow him wherever he goes*. Cathy had *grown up in a broken home;* she *knew* she *didn't want her child seeing their dad only on weekends*, so she chose to move south with Adrian.

During Cathy's pregnancy, *Adrian was not meant to be going on tour but, whilst* Cathy *was in the late stages of pregnancy,* Adrian *received notification he was going to Afghanistan* once the baby was born. After a *very traumatic birth*, Cathy and Adrian *had a baby boy, Charlie*. Cathy *discharged herself with her baby from hospital and returned home with Adrian*. Adrian was *deployed one week after the birth and Cathy was left at home*. Cathy was *struggling to settle with Charlie so her mum stayed and supported them for a short while* but, after her mum returned home, Cathy *was like in this complete anxiety; depressive state - couldn't do anything*. Cathy explained that her *mum being from an older generation said, 'don't ever tell anyone that you feel like that Cathy because your baby will be taken away from you*'. Cathy *struggled terribly* with Adrian *being away, waiting for him to ring, waiting for a letter; 'the bluey' coming through the door* and she began to *feel like she no longer wanted the baby*. Cathy knew *she had hit rock bottom and pleaded with Adrian to come home*. Adrian *was unable to come home but spoke to his Sergeant Major* whose wife visited Cathy. The *Sergeant Major's wife saved* Cathy and became *her main support for the remainder of the Adrian's tour*. With this support, Cathy and Charlie *found their own little way of dealing with life whilst Adrian was away*.

Changing times……..

When Adrian returned home from Afghanistan, Cathy felt that *he was like a different person, in some ways. It was nothing obvious, it was only that Adrian never showed any form of any emotion about anything*. Cathy noticed that Adrian *would generally just sit and watch a lot, like he needed to see everything*; but, for Cathy, *it just made her feel a bit uncomfortable*. Just as Adrian had behaved after Iraq on hearing a loud noise, this same behaviour also emerged. Cathy stated that on *hearing a car backfire or a balloon burst, Adrian's legs would give way; he would scramble to the floor finding it hard to cope*. There were *lots of changes* when Adrian came back. Cathy *had to get used to someone being in the house; doing stuff differently, doing it different to the way you do it,* so *as much as she could see a difference in him.* Cathy rationalised Adrian's behaviour *to the fact that he had been away for six months, and it would take time*. Cathy *first didn't realise it was a change in personality, that came much later*; as *more time went on,* the behaviours *never left* and Cathy began to think '*ok, so this is not the person I met, he's a lot different to who I originally met'.*

Two years after Adrian's return, Cathy and Adrian *had their second child, Grace*. Cathy's *experience with Grace was very different;* she then *knew what it felt like to have a baby and have that overwhelming feeling that you have when you have a baby.* She *never had that with Charlie* and, whilst things were more relaxed, there were other pressures impacting on the relationship. On returning from Afghanistan, Cathy stated that Adrian had a *problem with premature ejaculation; this went on for years and years and years until* Cathy *said 'that's me done now, we've got, there is nothing in this relationship apart from the children and we are staying together just for the kids*. Cathy and Adrian accessed *relate counselling through the army but never disclosed to them the full reason why they went*. They were *offered two sessions held in an army office, to scope out if the issues were army or PTSD related*. Despite the problems being an indirect cause, Adrian was told that it was *not something they would normally cover, and they would need to go private*. At this point, this was impossible; as well as *renting army accommodation*, they *had a mortgage on their own property* in the north of England. They *were living on a pittance* which meant accessing private help was not achievable. With all the pressure, Cathy said that she and Adrian began to live almost *separate lives*.

Cathy recalled how Adrian had *never talked about anything that happened in Iraq, and he never talked about anything that went on in Afghan, the things that he had seen.* If there was *any kind of confrontation, whether it be family or not, Adrian couldn't cope with it* or *deal with it*. The *first* Cathy *knew of any incidents during Adrian's tour was about six years after he had returned.* Since his return from Afghanistan, Adrian had *always avoided doing anything on New Year;* however, this particular year, Adrian had *visited their friend Simon's house party*; Cathy *didn't get there until about 11pm after finishing work*. When Cathy arrived, Adrian was *like completely out of his brain* which was very out of character for him; he didn't generally *get involved with anyone outside of work*. Cathy saw *Adrian and another man having an argument*. *Simon asked* Cathy *to take Adrian home;* by this point, *he was a crying uncontrollably*. Cathy *took Adrian home and returned to the party to speak to the man who was arguing to get a sense of what had happened.* The man told Cathy that *Adrian's very good friend got both his arms and both his legs blown off in front of him, they tourniquet all his limbs and got him to the medics. The lad survived right up to new year and, as midnight struck, he passed away.*

Over the years, Cathy said that she had tried to *encourage Adrian to invite people, friends into their lives* but *he won't let anyone in*. Cathy's friends often commented '*how lucky I am because Adrian's not one for going out or have any hobbies'.*

Although Cathy sometimes felt lucky, she knew it was because *Adrian says he can't have a hobby because everything in his life is dictated to by the army, they tell me when he can do this, when he can't do that.*

All of this went on for years, during which time, Cathy had *begged Adrian to access help which he didn't. After twelve years of marriage, with Adrian never showing anything at all, and with the last seven years of a marriage being really not a marriage at all,* Cathy said that she'd *had enough; there was nothing in the relationship apart from the children* and that they were *staying together just for the kids.* Cathy and Adrian separated; *Adrian moved into the block on camp.* At this point, Cathy said that Adrian *begged her to seek help together, to go to a counsellor.* The couple accessed private counselling *with a counsellor out of the area.* The counsellor *held joint sessions* with Cathy and Adrian and then *individual sessions*, Cathy stated that *she had worked a lot with Adrian one-to-one*. Cathy believed that the counselling had *saved our marriage, we are better than we have ever been in thirteen years, so yes, it's a happy ending*. The counsellor helped them to see that Adrian's problem of premature ejaculation was *a physical response to the trauma and army lifestyle because everything is always timed everything is always quick, everything has got to be done, to be ready then just wait*. Cathy described how *Adrian is a completely different man now: he will watch something on the television or, all of a sudden, he will get all emotional and he will cry.* They *have a bit of a joke about it blaming his age.*

This is me……..Cathy

Before Adrian went to Afghanistan, I was already suffering with what I believe was post-natal depression at this point so, when Adrian went, *I struggled terribly, so bad, I didn't want the baby. You then accept that it is just awful when they are away, but things will be fine when they are back.*

For the most*, I think for a long time I was just accepting, but then it didn't take a long time for me to be unhappy*. *I was unhappy, even when I fell pregnant with Grace; I wasn't happy then and that was two years after Afghanistan. I wasn't happy with the situation and, no matter how much I asked him to sort his issues out or to talk to me, it just fell on deaf ears. I tried all different ways of trying to get him to get help; in the end, I felt really frustrated, then at that point I had a mixture of emotions. I would be frustrated, we would argue, I would get angry, and then I would go from being angry to feeling bad because he hadn't really done anything wrong; he just wasn't giving me what I needed. I needed someone to sort of say 'this is what's* *wrong'. I needed him to say it. After having Grace, I detached myself, he was just the father of my kids at that point. I was deeply, deeply unhappy, I don't know how I stayed if I am honest. I think just purely it was because I know what it's like to grow up with separated parents and I just couldn't do that, the children adore their dad. I just cracked on, tried to make a life for myself and I left him doing what he was doing. I made my own friends, my own fun and I got myself a little job.*

I think Adrian's posting had a big part in this as well because, depending where you are, you have to completely change your relationship anyway. You have to either adapt or walk away. I was never going to walk away because of my kids and that is basically why I stayed. At this point, I was still begging him to get help and he still wouldn't plus you don't know what their reaction is going to be like either. I think coming from his wife for some reason it doesn't mean anything. The relationship at this point was a bit toxic.

When I found out about Adrian's friend in Afghanistan, it's like they feel they can't say anything to you or anyone else not even the lads, I think that is quite sad. We don't entertain new year at all but, just recently, we have started to go to family. Adrian doesn't let anyone in; it's just us that's it but, when it's just you, him and the kids its very intense. I often say to the girls at home 'you take it for granted if you want to go to the gym or do something when you don't have to think about the kids and Adrian'. We have to take the kids everywhere we go; it's always us, all of us together. We never get time where it's just me and him or even for him sometimes just be him.

For all these years, I've then felt isolated even from him because I couldn't keep on giving and trying to get something out of somebody, trying to support them. But they don't really give you anything back. I feel quite let down by the welfare system in the army. From a wife's perspective, I don't find them approachable; the whole system is not approachable because I can't just rock up into camp, knock on welfare and say there's an issue, I can't do that, it's usually the serving member that has to go in and say there's an issue. However, I will say, they were really good with Adrian. Just before we went for counselling, I did leave him, I had just reached the point where I just can't live this lie anymore, I just couldn't do it; I didn't have the energy, to physically do it.

We have and haven't had a terrible marriage and that's such a shame. I do say to him 'just think if you had got help when I asked you to get help, we would be in such a better place' and we probably would have had more kids. I do think if we had done *something our marriage wouldn't be tainted. I've recently created a photograph frame for Adrian for Father's Day, and I have sat there sobbing my heart out because it is so sad that for all these years our marriage has been tainted with this issue and actually it's only now that we are the happiest, we have ever been. I feel, we have all, kids included made so many sacrifices; we've missed so many birthdays, so many family do's, and we are both ready to be a part of it again.*

Sara:

'It's a real worry if something were to suddenly change'

Sara was another student at the university where I work who came forward after a talk by her guidance tutor. He introduced me to Sara and, after sharing the study's participant information sheet, Sara agreed to participate. Since Sara was familiar with the university, Sara decided that this was the best location for the interviews. We met in a small, comfortable office familiar to Sara. Sara shared her story openly with emotion especially portraying the strength from her experience. It was evident to see the happiness and relief when Sara spoke of the good days.

In the beginning……..

Sara and Tom *were young when* they *met*, Sara *was 16 and Tom was 18*. Everything *was ok, they were not perfect, there wasn't anything really odd about it all, it was ok*. Sara and Tom would *do their own thing as well* as being together. Sara and Tom have lived fairly local to family, choosing to *have their own home where Tom was able to commute to work* (whilst in the army) *every day.* Sara's dad had a long-term illness, and *in the beginning, she had quite a bit to deal with, so Tom didn't really meet Sara's dad until quite far into the relationship.* Sara's dad *had PTSD from what he had seen in the army* and, as a *result had drinking problems* which spanned over many years *since Sara had been a child*. Tom's mum had *schizophrenia so, over the years, Tom, too, has been exposed to and seen more than the average person in terms of mental health.*

In 2008 and 2009, Tom went on tour in Afghanistan; when *he went, everything was ok.* Sara, now aged 21, *worked at the local hairdressers*. Whilst Tom was on tour, Sara did the *family military training and found out what to expect; she was quite shocked as none of* what they were told *had been highlighted before*; Sara *got told what to speak about and what not to speak to them about. She said that the wives* *were advised if they* (partners) *come home and want to ask questions or if they want to speak about it, let them but don't ask questions.*

During his tour *in Afghanistan*, Tom *was quite unfortunate; he was on a Forward Operating Base (FOB) where he had no electricity, and no telephones*. Tom was part of a *platoon which required him not to leave his post; people's lives depended on him remaining in post until somebody was there to fill it*. He had *access to a satellite phone; however, when somebody was killed (which was quite often on that tour), the telephone lines were stopped.* Sara relayed a story about *when somebody on Tom's platoon had been killed*; another *wife had been on the phone to her husband at the time and the line went dead and she had said 'oh somebody has died'. Sara did not hear from Tom for two weeks because of this incident.*

Changing times……..

Sara said that she *first noticed a difference in Tom's behaviour when he* returned home from tour in Afghanistan in July *on R&R* (Rest and Recuperation) and failed to adjust. Prior to Tom's leave, *his uncle had passed away. Sara had been asked by Tom's grandad not to say anything* about his uncle's death *because he didn't want Tom's R&R to be moved and he didn't want Tom coming home at a sad time; he wanted him home when it was going be nice.* Sara did as she *promised* and said she *was really proud* that she *had managed to do what was asked* of her. Sara *picked Tom up* from the airport and he was drunk. *After driving around for some time, Sara took Tom to see his grandad*. Tom was told the news about his uncle's death, and *he was angry at* Sara *for not saying anything;* Sarah recalled, *it 'hit the fan' with that one*. Tom *ended up going off the rails; he was arrested for drunk and disorderly* behaviour, *and he just wasn't functioning like a normal person.* When on tour, Sarah explained, *they have defeated the Taliban, survived going past IED's (Improvised Explosive Device) and, when they are home, they don't recognise being bound by rules anymore, like they are immortal; they can't function normally, which was the case for Tom,* Sarah felt. Once he went *back away to Afghanistan, Tom seemed ok again*.

In November, Tom returned home, and Sara and Tom *went straight* on holiday *to Egypt.* Initially, Sarah felt, things were *absolutely fine in party mode* and then Tom *went really of the rails and then they settled again*. On returning home, Tom *couldn't manage just functioning day-to-day, being back to nine until five routines*. Tom *couldn't cope* and would have *extreme bouts of either being happy* and then *not being able to function*. It *would start with really random behaviour* and then Tom *would go completely off the rails*. Tom would *wake Sara in the middle of the night and his eyes would be open, but he would be asleep. Sarah remembered him shouting at her, like 'we need two helmets, we need them, we need them now*'. During tours, it is common for everyone to share music/media files. *Sara found Tom's iPod* on which, *as well as music,* she *stumbled across some awful photo's, not ones Tom had taken but ones which had been shared along with the music.* Sara remembered being *a little bit shocked and not really wanting to register what was in them.* She *made Tom delete them* but recalled that *Tom was completely desensitized to what was on there*. From a mutual friend, Sara was told that Tom had *volunteered to go to Afghanistan;* he had *not been called up* which *she couldn't understand* and whilst there, apparently, *he had enjoyed it*.

In the months following Tom's return, *he attended a number of assessment* meetings with military Trim (Trauma Risk Management), trained personnel during the decompression stage on return from deployment. It was during this time, that Sara *disclosed to a friend who was at the time Tom's Color Sergeant about Tom's bad dreams;* she recounted an occasion when they had *gone to the cinema; there was a gun scene, and he was cowering in the aisles,* and she *knew that things weren't quite right*. During this time, Sara's *dad died aged 51 from esophageal varices brought about from his alcoholism.*

Things settled for Sara and Tom, and *they went through a period of stability; Sarah felt that everything was great,* but Tom *would relapse at least once a year*. During a relapse, *it was if Tom would take the nice atmosphere away, like a mood hoover.* It was *drained off everybody and made everyone feel on edge. Tom doesn't snap but will take himself away; he won't join in anything and is reluctant to do activities and does everything in his power to avoid certain situations.*

When Sara fell pregnant with Jack and *Tom went completely off the rails*, it became apparent to Sara, that Tom *struggles to deal with any big change in his life*. Sara remembered *trying to organise* with Tom's boss *a surprise to pick him up early* from work and recounted that *Tom got really, really angry. It wasn't until after it clicked* for Sarah, *that it wasn't at all about coming home at a certain time from the army, it was* that *he was obviously sneaking off to do other things*. Sara *kicked him out*. *Tom moved to a flat* close to the family home for *six months and wasn't in Jack's life properly until he was about 14 months old.*

During this time, Tom *went to counselling, which helped whilst he attended.* Sarah felt that Tom *was in a really good place.* When Tom finished, Sara also *attended* *counselling*. In the months that followed and *when the counselling stopped, Tom's mood began to dip again, and he wasn't so good;* he announced that *he wanted a divorce*. At this point, Tom was *prescribed medication for depression and anxiety,* which Sarah *felt helped*. After *a year of taking the medication,* Tom had not had a relapse; he *left the army, took a civilian job* and was *now like a changed man*. Sara and Tom decided not to have any more children but *got a dog;* this change, Sarah thought, was *positive*, and Tom *is dealing with it really well*. Tom b*eing away from the army has not been a bad thing*, Sara explained; they *still have contact with people within the army but it's in a different environment*; even though he is out of the army now, Tom *still has that 'brotherhood' without the going away.*

This is me……..Sara

I have had (experiences with mental illness) everyone has experiences... experiences in both my childhood and with Tom, it started in my childhood and that's always been there.

When Tom was due home on R&R, *I kept to my word, I didn't say a word for his grandad, picked him up from the airport and I remember saying to Tom 'whatever you do don't come back drunk.' I picked him up and he was absolutely shitfaced*. He was *angry when he found out about his uncle's passing and that I hadn't said anything, but it wasn't my place to say, I couldn't say anything, and I was quite proud of the fact that I hadn't said anything*. During his leave, *I first found his behaviour quite funny, and I'd be laughing, but then I'd be thinking 'what the hell, what on earth is going on?' I didn't really know at first. I had seen things with my dad but didn't experience it firsthand until Tom so that was quite difficult.*

When Tom came home at the end of his tour, after the initial weeks it was *'come on, you need to get back to normal now, you've got to get back to what you have got to do from day-to-day'. It was just certain things... Fireworks he was ok with because he was expecting them but, if there was a loud bang or something, Tom was on edge straight away. It was scary to see, and I would be telling people around us that he is fine but inside I'm thinking 'god get up, get up'.* Tom had *extreme bouts where he was happy* or *really couldn't function; I couldn't cope with it*. *I disclosed this this to Tom's boss who was a friend of mine and Tom began to receive counselling.* I felt I too needed counselling, but *I was frightened that if I sought counselling it would go against me, or that it would make me and them think that I wasn't coping as a mum or as like a unit for the family*.

When I did go for counselling, there was a lot of resentment there, that I needed to shift if Tom and I were going to sort things out and move forward positively. *I was holding a lot of stuff back with my dad and never ever talked about what it was like living with my dad who had alcoholism and his PTSD.* That *impacted on how I treated Tom because I was quite angry, and I could see a pattern forming and didn’t want Tom to fall down the same route as my dad. That was quite tough, but it’s all worked positively really; we’ve not needed to have any interventions or anything like that.*

I am very mindful when he is not having a good day, it makes me feel anxious, I’m like on eggshells. I found that for a long time, I was questioning ‘am I making things worse or am I doing the right thing, being cruel to be kind, saying ‘see you later’. We (me and Jack) *now avoid any confrontation. My sister is a social worker and says, ‘the best thing to do is just take yourselves off away from the situation’, so we do, and it works. I’ve noticed more and more; I can work out patterns and I can see when I can push him a bit and say, ‘come on you know get yourself together a bit’ but then there will be other times when I think ‘I am not going to win here’.*

When Tom *is great, he is perfect; I feel like everything is great, like kind of perfect. It’s relaxed, it makes me feel a lot calmer; I’m not walking on eggshells. I’m not wary of his mood or trying to anticipate his reactions to certain things. I don’t have to withhold or disclose certain information so as not to upset him as much. But it is difficult and it’s a real worry if something were to suddenly change.*

We knew we weren’t having any more children. I wouldn’t dare take the risk and I can cope well with Jack if Tom was to go off the rails again; I know that I can pick Jack up and we could go, and things would be absolutely fine. But I know if I was to have more than one, or to go through that stage again, it would be too much of a shake up for Tom; there might be resentment there because he definitely doesn’t want any more children. It just wouldn’t be worthwhile, so we have settled on a dog but, even then, I have thought to myself ‘what have I done, if we do this is going to be a problem’. So far, it’s been good, really good.

I recognised the signs straight away, I knew exactly what Tom was suffering from, it was like PTSD, and I knew that he wasn’t behaving in a normal manner and may be that is why I stayed with him because most people would have been off a long time ago, people would have just given up. People have often said to me ‘why on earth have you stayed, what are you crazy?’ They have literally said to me ‘what is it that has made you put up with this?’ I often think, ‘I don’t know’ and wonder if I *just wanted to try to see if I could fix him, it is weird. I often think to myself, and wonder if I have done the right thing, even now I think, 'is it going to happen again?' Because you don't know, only time will tell. Tom was normal beforehand, and he seems to be normal now; it's just whether it reoccurs, or something will happen.*

Vikki:

'And I'm sat there thinking this might be funny to you, but this is my husband, and it's our life. I'm the one getting the brunt of it'

I met Vikki through one of the organisations with a strong presence of military partners that I had accessed during my initial recruitment drive. Vikki had known about my study from the initial introduction and, at a later date, was curious about how it was developing. Vikki then came forward saying that she would like to tell her story. I met Vikki at her home. The interviews took place in the front room with a cup of tea. Vikki was a little nervous to begin with but, once she started to tell her story, she was open and at ease. Vikki had a nervous laugh and comedic tone when telling some of the difficult parts of the story.

In the beginning……..

Vikki *met Darren in March 1999 whilst on a night out*. Vikki was *out with a college friend and Darren was out with two friends who were also in the army. At first,* Vikki *had agreed to see one of Darren's friends until she had found out that they were all going to Kosovo the next day for six months*. Darren and the other friend *shared their addresses asking* Vikki *if she could write to them whilst they were away*. *After writing to Darren and his friend Shawn, Darren then asked* Vikki *out on a 'bluey' and asked her to spend New Year* down in the south of England *in his hometown*. *Shawn had told* Vikki *that Darren drove*, but it turned out that *he didn't*. Vikki *decided to spend Christmas with her parents but that she would go and see Darren as it was the Millennium*. Darren returned *back from Kosovo the day after Boxing Day to an airport* near to Vikki in the North of England. Vikki *picked him up* and *they drove to* the south of England *which was an experience* as she *had been a qualified driver only for 18 months.*

When Vikki went to Darren's home, *there was his mum, his sister and a dog.* Vikki stated that *Darren had had a troubled childhood; he had lost his dad when he was 10*. Darren *proposed to* Vikki *the day before New Year's Eve,* and Vikki *said yes*. Darren returned *back to work* in *early January and was away until March,* then Vikki and Darren s*tarted looking for a house together*. Vikki *never moved about* with Darren's work, explaining that *they did once look at getting a quarter before getting married, but they could only have a house two weeks before they were married.* Vikki *didn't want to wait for army quarters and didn't want someone coming with white gloves inspecting it* when they have to leave and move to a different location*. So, they bought a house in the November;* they *wanted to know it was theirs* and they didn't have to keep relocating every time Darren had a new posting. hen Vikki and Darren got their first house, Darren was on *tour in Kenya, so* Vikki *did the move herself*. Vikki and Darren *married in June 2001* and then *he was posted to Cyprus*. Darren had worked in the army *all over; he did six months in the South of England.* Vikki chose *not to go with him as she would have lost her job and there was no point being down there with no money*. So, Darren had *always* lived *married unaccompanied or travelled* from home were feasible. Vikki *felt that this had either worked or been a complete nightmare; like when he was based on another camp down in the South of England as it meant he would travel down to work on a Sunday night and then travel back to* Vikki *on a Friday night; so, he was absolutely knackered.* Darren *stayed in the South for about nine months* and then moved closer to home. Darren had *also been to the Falklands twice, completed two tours of Cyprus, and been to Kuwait, Iraq and Sierra Leone.*

Changing times……..

According to Vikki, when Darren *came back from Iraq in 2003; it started to go funny*. Vikki was *out at a friend's birthda*y when Darren returned *home from Iraq*; he had *come home earlier than expected*. It was a *Saturday night;* Vikki *left the friend's birthday to pick Darren up from the airport to bring him home*. The *following day*, Vikki had *arranged to go to her godmother's husband's 50th birthday*. Vikki and Darren *stopped by Asda to collect a balloon*. Vikki *only had a small car at the time and the balloon was in the back of the car held in place with a weight on the tie*. On arriving back home, they *opened the boot to get the shopping out, the balloon came out, but the weight kept it in the car*. Vikki recalled that Darren *just hit the deck* and she had thought '*what on earth is the matter with him? What would make him do that?', But, she explained, it was obvious when thinking of where Darren had been; he was still on high alert, it is going to take forever to come back*. This was the beginning; Vikki reported that Darren's behaviour *became a nightmare for her*. *Darren blamed* Vikki *for not listening to him, not doing anything for him and he was kicking off about anything*. On one occasion, Darren took a *train down to the South of England without telling* Vikki*; he disappeared down to his hometown for two* *weeks where he was going out drinking everyday with his sister;* this was *not something* Vikki *would have done.* Darren was *very argumentative and just not in a good place* although he *did seek help* and *did see a military psychiatrist or Community Psychiatric Nurse (CPN)* (Vikki wasn't sure which). The appointment was attended by both of them; however, Vikki felt that the experience was far from productive with the practitioner falling *asleep while they were talking to him*. Vikki did speak up *saying 'are you alright'* and was given the explanation that the clinician *had travelled up from the southwest of England that morning. Things settled* and *in 2005,* they had *a son, Christopher,* followed by the birth of their *daughter Annie in 2009*. Darren *was fine up until 2016*. Vikki recalled that 2016 wasn't a good year for them; a house that they had bought just 18 months before needed extensive *repairs,* which had financial implications, as well as requiring them to *move out for two weeks*. *Darren was away during this time in Sierra Leone* which meant that Vikki had *the worry of that too*. On his return, whilst Darren *seemed to be ok,* Vikki felt that he began to *speak to her like she was recruit* (recruits are generally addressed a firm and assertive manner). She *wasn't sure if it is just the military thing*. In the September, Christopher, their son, had a *serious leg break during a rugby game, which meant that his leg was in plaster for twelve weeks*. Despite seeking compassionate leave to help care for his son, Darren was *unable to take any time off.* This was compounded by the existing problems that Darren was *experiencing in work with his Staff Sergeant.* Restrictions were imposed and *there was a number of petty little things that caused Darren to be on edge constantly, so when the phone rang or anything like that*. In the following July, Darren *just totally flipped*. Vikki had gone to the hairdressers and had left Christopher and Annie at home with Darren. Vikki described receiving a *phone call from Annie then aged 8 years who was crying and saying 'can you come home? Dads having a go at Christopher* and *Christopher (aged 12 years) has walked out'*. Annie had stayed at home and Christopher had walked to Vikki's friend's house which was about a 10-minute walk away. Vikki described how *Christopher didn't even have time to put his trainers on; he just thought 'I'm getting out of here'.* Darren then *just disappeared.*

Darren went *to live on camp for a while*; he *referred himself to the doctor* because Vikki *had told him he wasn't staying in the home unless he went*. Darren saw the doctor and asked if Vikki would attend with him; he was *referred to the military CPNs and given a sick note.* On submitting the sicknote to the staff sergeant, Vikki felt that no privacy or empathy was shown; for Vikki, *it was not how you would expect someone to treat someone when they've got signed off sick with a mental health* *illness*. Whilst Darren was under the care of the military CPNs, *it seemed to help and everything like that*, but *psychologically what it did to the kids, where they didn't even feel safe in their own house has been the impact.* Darren then *lost his mam*, so *after losing his dad at 10*, Vikki said that Darren had disclosed that *he wasn't allowed to cry, that it was selfish to cry when somebody had died.* Vikki thought this belief *had come from his mam, but it wasn't, it was internal; something Darren had* decided for himself. Vikki believed that some of his mental health issues were brought about by grief, that *he hadn't sort of let the grief out of him, the emotions, there is a lot inside of him and he's not let go*. Vikki said that she *had now put a lot down to his childhood as well as the army*; Darren seemed to mellow out for a little bit; however, Vikki was unsure if this was due to Darren growing older, or because he was nearing retirement from the army.

This is me……..Vikki

When Darren first came *back from Iraq in 2003*, *when he just hit the deck, I thought 'what on earth is the matter with you, what would make you do that?' I then obviously started thinking of where he had been and that he was still on high alert; it seemed like it was going to take forever to come back. And when he got the train to go drinking for two weeks, I thought 'well that is obviously what you were after', but I knew I wouldn't have given him that, I blamed myself saying 'well I'm quite boring staying in' and, at this time, I thought the problem was me.* During this time, when Darren tried to get help, *I went with him, and the psychiatrist fell asleep. I was sat there thinking 'this might be funny to you, but this is my husband', do you know what I mean? And it's our life. I'm the one getting the brunt of it. It was just a nightmare.*

Then *things settled. On good days, when Darren was happy it was good; we had a happy home, it's nice, how a home should be, it reminds me of my home growing up, a nice place.* But when it started again in 2016, *I wouldn't dare speak, it was like walking on eggshells literally. He would flip over anything, so if I'd said 'do you want a cup of tea?', He'd say 'yes', and I would make him a cup of tea and then he would kick off saying he wanted coffee. It was little things; it was awful, I just wanted to grab hold of the kids and run away, it was that bad. As well, when things were difficult for Darren at work with his staff sergeant and because of how he would then come home, I could quite happily of lamped the staff sergeant because what they gave to Darren, he gave to me, took it out on me. They don't realise, I get accused of not listening all the time, 'I'm like, you are joking, aren't you?'*

I went with him to the doctor's a couple of times; he did ask me, but I wanted to go along anyway to make sure he was telling them what was going on. I suppose I was just holding out really, clinging on to a string, waiting for it to give way. He saw a couple of different doctors, but *one was really blunt, it was what he needed*. They said '*if you are feeling like you are losing control, you get up, you remove yourself from the situation and go and have 10 minutes in the garden, go and sit in the car, go for a walk around the block. You're in control, you sort yourself out'. I could have hugged them. Other than that, I wasn't involved in any of the other therapies,* (counselling and reviews of medication)*, I just sort of clung on as you do, I didn't want my marriage to break.*

It's like when I'm just at work and hear on the news about a train incident. You know what mood you have left them in and stuff like that, I just don't know if it is them or not. When they are like that, even if they sort of say they would never be that stupid to do it (take their own life)*; but you just don't know, do you? You just sort of live through it, thinking you've got to. I think, had I of known then, what I know now, I don't know whether I would have married him; it's a hard thing to say but it is true. But what issues would I have had with anybody, there is good and bad in everybody. I don't think I would have got through half of it, if it hadn't been for my mum and dad because I would just tip up at the door or ring them to say, 'I'm coming over with the kids' and they were like 'yep that's fine, not a problem'.*

Sophie:

'But you know it's better now, like it's never going to be 100% 'cos once it's there, it never really goes away'

I met Sophie through one of the organisations which had a strong presence of military partners. Sophie was a friend of another participant and came forward to give her story sometime after the study commenced. Although Sophie approached me, she was a little apprehensive and emotional during our initial meeting. I met Sophie at her home, where she showed me her wedding photo, taking pride of place on the front room wall. Sophie was shy and a little cautious at the start of the interview; but, once she began to share her story, opened up a little more. Sometimes, Sophie became emotional and tearful; displaying frustration and anger when talking about how Nathan was treated.

In the beginning……..

Sophie and Nathan had been *together since 1997 although they knew each other a bit before then.* Sophie was *quite young when she first met Nathan*, it was when *she worked as a Saturday girl on the market.* At this point, they just knew each other. Nathan then went off to join the army, going away for a few years. Sophie and Nathan then *met up in a nightclub when* Sophie *was 16 and that's when they started in a relationship*. They got *married really quickly because of the whole army situation. They probably would have been together a lot longer before getting married, but it was because at that point to live together* in the army *you had to be married.* Sophie recalled that it all *started off quite well.* They were local to their hometown because Nathan was at a camp nearby. After a while, *Nathan was posted* to the South of England, Sophie *went with him,* and they were *there for five years*. That was as far as Sophie travelled as an army wife. After that posting, Nathan was *posted back* to a camp local to their hometown again and that was when Sophie felt *things started to kind of unravel for his work; it was the catalyst of when things started to happen.*

With a new posting, Sophie and Nathan were back to a camp local to family. Nathan had *been promoted* and was in a *more senior role; even though there were people above him, Nathan was doing and taking on a lot of responsibilities*. It was *the run up to a tour of Afghanistan in 2010 and Nathan was doing a fair bit, but the kind of responsibilities all seemed to be that little bit heavier at this point* and the *whole mood* of Nathan and the regiment *had changed*. *When they came back from Afghan, a lot had changed for the regiment and for Nathan*. For the seven and half months Nathan was away, Sophie had to *take on the responsibility of everything, all the bills, banking, everything*. *As an army wife*, Sophie said that she *had to be like that and it made* her *more independent.* However, she felt that *it is not necessarily seen as a good thing in a couple*. Sophie explained this by describing how when Nathan came home, he had said *'well you don't need me now because you do it all'*. Nathan didn't show any other signs of anything problematic at that point.

Changing times……..

Sophie felt that the stress and depression *started to escalate in 2012:* the regiment were going on tour again, but Nathan had to *stay behind on rear party*. During his tour in 2010, Nathan had sustained a *back injury which meant at times he was unable to feel his leg*. Sophie said that *Nathan wanted to go on tour; he felt that it* *was his job to go and did not feel part of it because he was left behind*. *Things at work then changed;* in Nathan's department, *there should have been two people of higher ranking above him*, but *Nathan was the one running it as there was nobody else there to do it*. Sophie described how Nathan *was told that he was key personnel; he was needed to stay back* during this tour and, Sophie felt, *that's when it started to affect his emotions*. Nathan's *appraisals would state he needed external postings but then he wasn't released because he was key personnel; so he was left feeling he was doing his absolute best but getting nowhere*. The demand placed on Nathan at work and staff shortages meant Nathan's *stress levels became worse and worse; the stress started piling on him and the depression started and that's when it all started exploding*. Nathan *would come home not happy, but then still wouldn't be happy on his days off so* Sophie *started to think that 'it must be here at home' that he wasn't happy.*

In 2015, Sophie and Nathan made the decision to buy their own home. *The moving date was set but then Nathan was told he was going to Canada.* There were two flights: Nathan was *due to fly on the first one, two days before they received the keys to their house*. Nathan placed a request to go *on the flight four days later so he could help* Sophie and their son Sam to move. The *request was denied*, and Sophie *moved to the new house on her own*. For the three months out in Canada, Nathan disengaged; he *just sat there and said, 'I'm just not interested'*. *It was obviously detrimental to his working life, but he was like 'well they are never gonna help me, I'm never gonna gain that mutual respect' and that impacted Nathan more than anything else,* Sophie felt.

After the Canadian tour, the regiment was then posted to the South of England, but Nathan requested to stay behind. Sophie didn't want to move at this point since Nathan only had three more years left in the army, and they had bought a house. *They wouldn't let him stay so Nathan applied for redundancy which was also declined*. Nathan had to go, so the decision was made together that Sophie would stay in the family home with their son Sam*. Nathan didn't want to go and* Sophie *didn't want him to go; it then became a 48-hour marriage, a 48-hour family*. Sophie described how Nathan *would come home on a Friday night and travel back to work on a Sunday afternoon*. *It got to the point where Nathan didn't want to come home because of the journey*. Sophie recalled that she *took offence at that* and eventually it led to Sophie *suffering from depression too*. She recognised that Nathan was *dealing with a lot of pressure at work* and then pressure off her *because she wanted him home every weekend, but the journey was just too long*. Both Nathan and

Sophie *were in the grips of depression* and Sophie remembered a *really bad atmosphere.* Nathan *didn't overly shout that much, but then he would go 0-60 when in a mood, it went from nothing to all of a sudden, things got slammed or banged down; Sam would get shouted at*. Nathan was *so stressed out and feeling like he had no help, no one to turn to; he was still feeling pressure from above regardless of what he did.* As a result, Nathan's depression worsened and there was an incident involving Nathan and another soldier; *Nathan lost it, he hit the guy*. At this point, Nathan *had been seeing the doctor for his back injury, but he took himself back to the doctor and said he 'just couldn't cope anymore'.* He explained that *he didn't want to be at that camp, and that he needed to be home*. The doctor had already suspected that Nathan was depressed, but this had not been discussed until that point, *two years from the start of the depression*. *Nathan was signed off with depression and sent home. Nathan was given talking therapy which he did for a bit and then stopped, saying he'd had enough, 'I'm going nowhere with it'*. During this time, there was *quite a fair bit of time worrying about the outcome of the incident*. Nathan *wasn't happy at home, nothing ever seemed to make him happy and he never hardly seemed to enjoy anything.* After a few weeks, Nathan had to return back to camp, and on his return, he explained to Sophie that *'he just couldn't do it'* anymore. After about three months, Nathan secured a post back near to his home where he was able to complete his final two years of service. Any further promotion was declined. As the situation improved, so did Nathan and Sophie's mental health; *it's better now for both of us; it's never going to be 100% because once it's there, it never really goes away.*

This is me……..Sophie

So, we, as army wives have to be like this; I had to take on the responsibility of everything, it makes you more independent, which is not necessarily seen as a good thing in a couple. Nathan didn't think I needed him anymore when he came back from Afghanistan. When he returned in 2010, *I still feel that although he wasn't showing signs of anything problematic at this point, there were occasions such as at a mess do where I remember seeing a guy in floods of tears and saying, 'he needs help' and Nathan and others just said, 'he doesn't want it'. But I was like, 'but he needs help', and nothing ever came of that. Even now, stories are coming out (*about Nathan*) now that I hadn't heard previously.*

In 2012, when Nathan's depression started, *I thought 'it must be here at home' because when he is here, he's not happy. And then, as it escalated when he was* *posted down south, I thought 'there must be something wrong'. I always took it personally that he didn't want to see me, when he didn't want to be at home with his family, travel home for the weekend. I know the drive, it's just so long and I knew Nathan just didn't want to do the journey, but I was taking it personally and had that feeling. I took offence and that's when I started suffering with depression as well. I was always tense and just hunched over waiting for something to happen, for something to set him off. It made me frustrated and angry as well. I used to say, 'well just tell me what's wrong, I can't fix it if you can't tell me'. It's just so frustrated because he doesn't tell me when something is bothering him either, so my minds going ten to the dozen wondering why he is in a mood, to what has put him in that mood and whether anything I've done has put him in that mood. I am constantly trying to over think what could possibly put him in the mood in the first place to try and fix it.*

After Nathan was signed off sick and *he had counselling it was down there* (at the army base). *Not once did anyone talk to me; all Nathan ever said was that he had doctors' appointments, that's all he ever said. He never told me anything about what happened there, I was never asked to be included and I was never told any outcomes other than what Nathan would tell me which was not very much, because he didn't want to talk about it then. I was out of sight out mind; I do think Nathan did mention that I was suffering from depression, but they didn't come and see me, but I don't think I would have talked to them anyway, I don't think, because they are like just another soldier in that role, they've not been specially trained for it in any way, so I don't feel like they would be able to give me any type of advice.*

For me, I would say I'm better, I refused any kind of tablets, I didn't want tablets. I did do some talking therapy like just phone conversations and that did kind of help, but once Nathan was back home, *I was better, and it got better over time. I am still prone to bouts* of depression, a*nd I think it's always going to be that way. It's also had a lasting effect on Nathan as he now stresses and gets uptight about things, even though he has left the army. It is more relaxed because I'm not waiting for the moods or the flying off the handle as much, we can have a good day; it's chilled out and fab.*

5.4 Chapter conclusion

To conclude, this chapter has highlighted the participant and relationship characteristics and has illustrated the participants' individual stories. By using the ‘holistic’ approaches within Lieblich et al.’s (1998) framework, each individual story has been considered as a whole and the parts within it. The stories are presented using participants’ own words to reduce misinterpretation, provide context and allow understanding of the meaning from the participants’ points of view. Adopting this analytical approach has allowed me to stay true to the ethos of a biographical approach using life stories interviews. As discussed in chapter 4, the subjective meanings of the individual stories and the experiences within them have been presented as a whole. This gives context and offers a deeper understanding the preceding times prior to their serving partner developing a mental health issue; an insight into the relationship. From a researcher perspective, the amount of interpretative dialogue with the stories allowed me to become fully immersed in the data which facilitated a deeper familiarity with the utterances throughout the stories and the subsequent identification of subcategories and categories. The next chapter presents the findings from the category-content analysis.

6 Chapter 6. Presentation of findings: Identification of categories

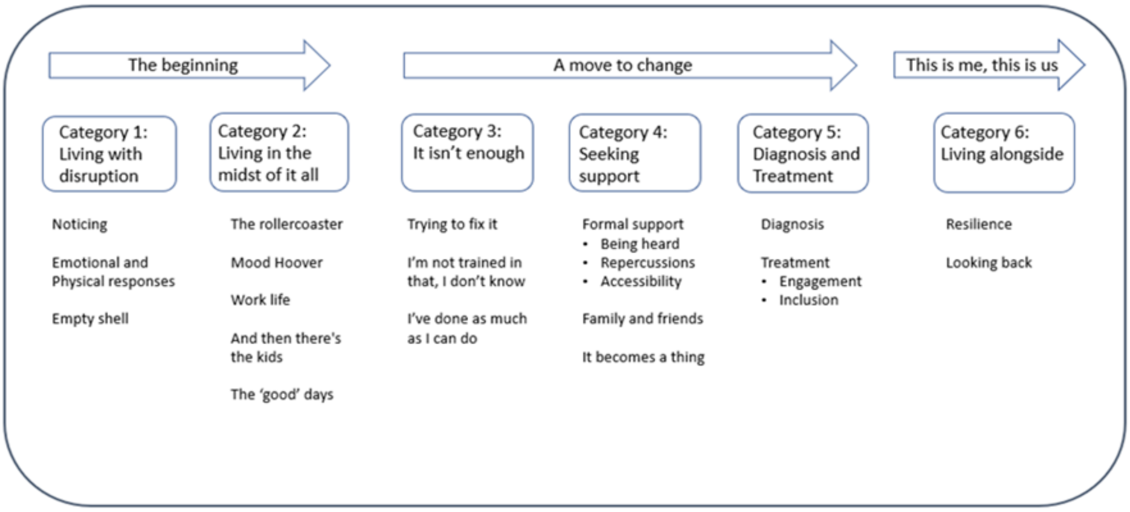
6.1 Introduction to chapter

Following the holistic presentation of participants' stories in chapter 5, which used Lieblich et al.'s (1998) two-stage life story analytical approach, this chapter focuses on the findings from the category-content analysis of the interviews (Lieblich et al. 1998). To begin the category-content analysis, I revisited the study's aim: to explore military spouses' experiences of living alongside a serving partner with a mental health issue. Through ongoing interpretative dialogue with the transcripts (see chapter 4), I formulated six main categories from the initial 21 subcategories, synthesising these into a conceptual framework illustrative of a journey depicted under the headings: the beginning, a move to change and this is me, this is us. The depiction of a journey is typical in narrative research (Plummer, 1995; McAdams, 1997).

Figure 11 below, illustrates this and is used throughout the chapter to revisit the journey as a whole, but also to emphasise the specific categories and subcategories being discussed; these will be highlighted in bold with the other categories and subcategories 'ghosted' out.

Drawing data together under different categories and subcategories, I seek to highlight patterns, find commonality and also identify negative cases amongst participants' experiences. Where particularly useful, I touch on the policy, theoretical and empirical literature in order to illuminate and provide context but discuss this literature in more detail in chapter 7. All quotations from participants are shown in italics. Where a word appears missing or does not make sense, I have inserted my own words, in square brackets, to assist the understanding of the quotation. Each quote has been chosen to illustrate a particular category/subcategory; the quotes come from different participants, each of whom has a pseudonym. As a reminder, military spouses are the 'participants' and are referred to as participants, their pseudonym or military spouse. Their wives/husbands are referred to as serving partners.

Figure 11: Diagram of journey, categories and subcategories



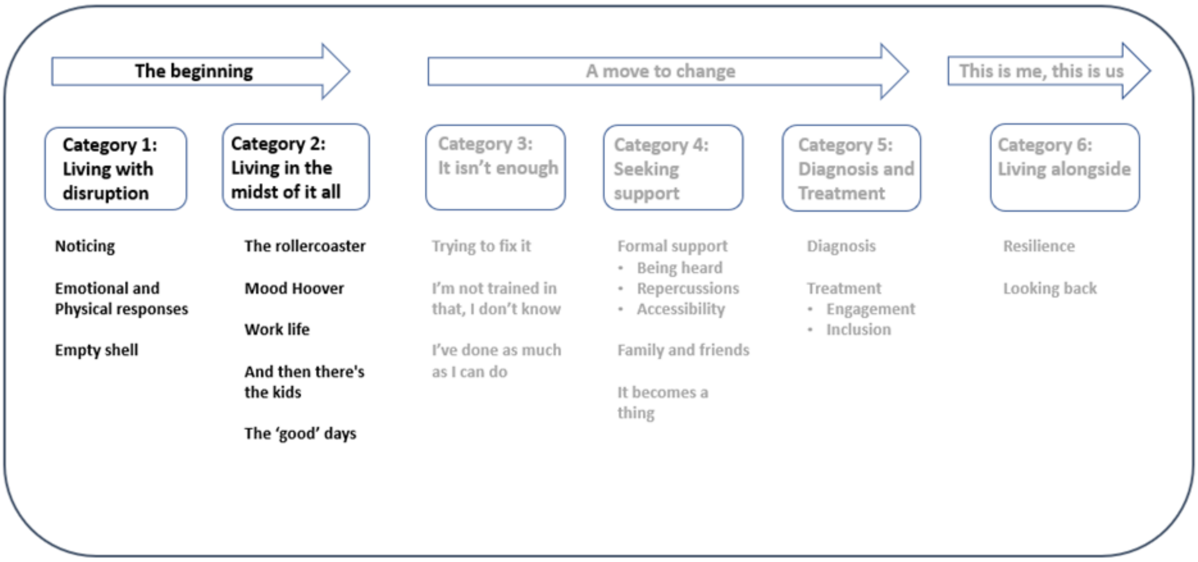
6.2 The beginning

The initial feelings, symptoms and behaviours observed in a person with a mental health issue are varied and wide ranging (NHS, 2022). Very often, family members recognise changes in emotional and physical behaviour earlier than the person experiencing it. An individual's trajectory of a mental health issue is problematic; repeated episodes of illness over a lifetime are difficult to predict. Such episodes present in amongst periods of remission before relapse and recurrence again (Frank et al., 1991, Burcusa and Lacono, 2007, Green et al., 2013). Periods of remission vary between a few days to weeks or months - dependent on the type of mental health issue (Burcusa & Lacono, 2007). Similarly, the longevity of such episodes, not only has an impact on the individual (in this case, the serving partner) but also impacts on other relationships; for instance, with partners, children, friends and work colleagues (Sherman et al., 2008; Mansfield et al., 2014; Brown, 2015; Waddell et al. 2016, 2020).

Recognising a mental health issue within a UK military context, Long's (2021) study found that military spouses would observe and interpret behaviours according to their understanding of the serving partner's past deployment and how they worried that dormant mental health issues could surface after their return. Long's (2021) study questioned however whether military spouses may have '*looked for signs'* because of the welfare briefings that they received, rather than before this time During times of deployment, military welfare services provide family briefings to military spouses and their families; within these briefings, families are advised about behaviour changes and observing for such changes. Deployment inevitably initiates disruption and a change for all family members. On return from active service, a '*new normal'* is sought by all family members; however, the effects of deployment for some serving partners means that adjustment back into home life is problematic (Lapp et al., 2010; Long, 2021). Acknowledging the emotional cycle of deployment (Logan, 1987; Pincus et al., 2001), (discussed in chapter 3), the stages of post-deployment and re-unification are associated with unique emotional stressors for three to six months after the return of the serving partner (Esposito-Smythers et al., 2011; Lowe et al., 2012). Consequently, the lack of adjustment and the prolonged difficulties in securing a new 'normal' after six months, such as continued violence, anti-social behaviour and alcohol misuse can be indicative of mental health issues such as adjustment disorder (MacManus et al., 2012).

This part of the journey depicts those initial moments when participants noticed disruption and changes (category 1: Living with disruption) in their serving partner in terms of the manifestation of a mental health issue. A noteworthy point here is that not all of the participants' serving partners mental health issues were as a direct result of deployment or a combat situation. This is followed by their experiences of living in the midst of the disruption and changes (category 2: Living in the midst of it all). At this point, no formal diagnosis of a mental health issue had been made (see chapter 5); within the participants' stories, diagnosis occurred much later, where either the military spouse or their serving partner had reached a point where they did not know what else to do (category 3: It isn't enough). Extracts and quotes chosen from the stories are presented below to illustrate those early moments when participants first began to notice changes in their serving partner's physical and emotional behaviours and how, following these changes in behaviour, they lived with their serving partner day-to-day. Some of the subcategories comprise participants' actual words, such as '*the rollercoaster'* and '*mood hoover'* since they encapsulated the experiences of the participants but also offered an easily recognisable visual metaphor of the situation. Other subcategories, such as the 'good days' was a phrase I used as a point of reference during the second interview to elicit any differences between the participants' experience during the good and bad days although the phrase '*good days'* was indeed used by Christina. Figure 12 illustrates the categories and subcategories within this part of the journey: the beginning.

Figure 12: The beginning



Living with disruption

This is the period when the participants realised, felt or observed prolonged changes in the behaviours of their serving partner that were disruptive to the relationship and the family unit. It has similarities with biographical disruption theory where Bury (1982) describes disruption to people's narratives as a result of illness; the illness and its consistent presence in everyday life, fundamentally changes how people understand themselves and their future life (explored further in the discussion chapter 7).

Whilst these exerts do not necessarily illustrate the military spouses' thoughts and feelings, it is important to acknowledge them as they create a meaningful illustration of context to the responses that follow within the rest of the findings. Within this category, three subcategories were identified: *noticing*, *emotional and physical response*, and '*empty shell'*.

Noticing

The disruption to homelife on the return from a tour was recognised by Lindy, Simone, Cathy, Sara, Vikki and Sophie; with examples of the serving partner's initial days at home specifically highlighted by Lindy and Vikki. As discussed earlier, there is a complexity to mental health issues; the symptoms, causes and/or triggers can be multiple and varied, as can, potential risk factors. For both Lindy and Vikki, the initial signs were obvious to them, although their spouses presented with two different behaviours, both (behaviours) were indicative of mental health issues. This is Lindy's description of Craig's first few days at home following deployment:

> *...even for a couple, for a few of days afterwards, he would almost sit in the dark and he wouldn't want to eat with a knife and fork, you know, he was still kinda like, kinda that adjustment.*

Whilst Lindy's partner Craig, appeared more withdrawn and silent, Vikki described something very different on Darren's return home from Iraq in 2003. She stated:

> *He was just a nightmare when he came back, he was just like, I wouldn't listen to him, I wouldn't do anything for him, [he was] just kicking off about anything.*

After a few months, Vikki felt that things had begun to settle and that her partner was '*fine up until 2016'*, just as was recognised and acknowledged in the earlier discussion of the emotional cycle of deployment (Logan, 1987; Pincus, 2001). Cathy, who had a small baby and had suffered from post-natal depression, thought:

> '*they have done their tour, it was awful, but they come back'.*

Cathy's spouse Adrian's previous lack of emotion when she had miscarried and Cathy's post-natal depression during Adrian's tour made the initial signs of Adrian's withdrawal much harder to spot; she described:

> *When Adrian came home, he was a different person like, but he's like, he wasn't.... It was nothing obvious about Adrian, it was only that he never showed any form of any emotion from anything*.

Indeed, it was nearly three years until Adrian's mental health issue which was anxiety was fully recognised by Cathy.

When Cathy and Sara first noticed the early changes in their partners' behaviour, their response was one of paradoxical laughter; a common physical reaction to stress, confusion or anxiety (Granitsas, 2020) which in their cases, seemed to arise from uncertainty and disbelief. As Sara recalled:

> *...at first it was obviously quite funny, and I'd be laughing, but I would think to myself after, 'ee god, what on earth is going on?" I didn't really know at first.*

For others, the disruption was gradual and escalated over time. When Christina's serving partner, Daniel, first started in the army, his anxiety of being away from her began and this increased over time. Christina described how Daniel's level of anxiety and then depression increased as the years went by, to the point of him being admitted to hospital due to his physical symptoms:

> *[Daniel] has always, always, always suffered and it's just got worse and worse and worse with stress and anxiety… this time last year when the pains started, when he started to get the pains in his throat and the pains in his chest 'erm and he still gets the tightness in his chest… I knew that there was obviously nothing wrong with his ticker really, thought it was anxiety driven.*

Christina explained that Daniel's anxiety was only present when he was stationed in England. During his tour of Afghanistan in 2012, Christina did not feel that Daniel's anxiety was as bad because of the physical distance between them, he was able to compartmentalise it because he was away doing his job and not given a choice about whether to go or stay. She explained, '*whereas in Afghan, we had no choice.'*

For some serving partners returning home, the period of adjustment to civilian life does not end. For them, the prolonged changes in behaviour following deployment can be attributed to the military and their experiences whilst away, as was the case for Simone's serving partner, James. Simone stated:

> *I think for me, it was coming back from Sierra Leone, when I think about it, it was, it spiralled from there.*

Simone explained how the changes in James' behaviour persisted and his low mood continued to decline:

> *Morning time on a normal day, he would be fine but then, when he came home on a night, there would be no conversation or like, which has been going on for quite a while, or like I say he would be drinking every night, but he'd come on a night and would be drinking, every single night, not loads but he would drink every night, whereas that is not normally what he does.*

She went on to say that James:

> *Saw the worst things there [Sierra Leone] and he said he thinks about them all the time, or he will wake up thinking he's there.*

The tour to Sierra Leone was in 2015; Simone highlighted that, as a result of James's depression and a minor knee injury, James was medically discharged in December 2017:

> *...so he got discharged in December... he went on sick for quite a while, he was on sick quite a lot 'cos he was struggling.*

Following his discharge, James was diagnosed with PTSD.

Sara first felt the disruption to her relationship with Tom during 'R&R' leave after his tour of Afghanistan; again, this was indicative of serving personnel's struggle to adjust back to home life. She described:

> *It wasn't until he came back on R&R that I noticed there was like a difference in his behaviour and then he went back away, and it was ok.*

Like other participants, Sara described how Tom's behaviours were prolonged by means of fluctuation in mood and his drinking. Since the tour in Afghanistan, Sara recognised that Tom's mental health issue was also compounded by other major life events such as his son's birth; again, revealing the complexities of mental health issues and how the causes and triggers are wide ranging. Sara shared how they went on holiday once Tom had finished the tour and returned home in 2008. Tom stayed at home until their son, Jack was born in 2012. Sarah stated:

> *He was fine on holiday, but he just went really off the rails and then 'erm things settled down a little bit after that then we were 'erm trying for a baby and we got pregnant with Jack and then he completely went off the rails… But he would start with really random behaviour and then he went completely off the rails, and I remember, we went through a period of like stability where he started to level out again but at least once a year he would have a bout and he would always just completely go off the rails.*

In comparison, Vikki, Lauren and Sophie's serving partners' behaviours and later, their diagnosed mental health issue, appeared to manifest from work demands and increased stress levels while based at home in the UK. Increased stress levels as a result of work demands were coined by Brooks and Greenberg (2017) in their systematic narrative review as '*non-deployment stress'* (p80). As UK military serving personnel, individuals routinely change posts every two to three years, meaning that work teams regularly change with members joining or leaving. Work teams therefore are in a state of change and new members can impact both positively and negatively on the dynamic within the team. Vikki explained the relationship dynamics within Darren's work and the negative impact it ensued:

> *In 2016, Darren had problems with his staff sergeant* [his superior] *at work at the camp and this lady, if you can call her that was an absolute bitch for*

> *one of a word, she was making everybody's life hell. They would stay behind on a Friday afternoon to watch her iron her kit because they hadn't done the hours, or no you can stay, so she would iron her kit, they would have to watch her do that and then she'd like let them go. It was just petty little things, but it was all these little things that, he was on edge constantly, like if the phone rang or anything like that 'erm but since then I think I know of three that have left, and I think there was two that went on the sick long-term from her.*

Sophie recognised the impact on her serving partner, Nathan, of the changes within his regiment following his return from deployment:

> *...when they came back from Afghanistan, that's when I think a lot of things changed for his regiment and then obviously at home as well.*

However, she noted a greater change as a result of non-deployment stress when it was the regiment's second tour of Afghanistan. Sophie described how Nathan remained on '*home soil'* to keep things running. The related stressors of role commitment and conflict, work overload and demands on Nathan were evident in Sophie's recollection:

> *It was kind of more the 2012 one, where he stayed behind; he was on rear party for 2012 and he wanted to go and he felt not part of it because he was behind and this is when for his work, they started, I think, not treating him right. He was the one running his department, even though there should have been two people in higher ranking above him, and he didn't have those two higher ranks above him, there was nobody there to do it. He was running that department; he was feeling left out because he hadn't gone, and he was feeling like it was his job to go, and he shouldn't be behind. But then they started using him as like key personnel – your key personnel 'you can't go here, and you can't go there'. So then it started to effect his emotions because his report would say 'he needs an external posting' but he couldn't go because he was key personnel and he was then feeling he was doing his absolute best but getting nowhere and that's when the stress started piling on for him and I think the depression started for him as well and that's when it all kind of started exploding.*

Lauren, however, believed Damien's depression had surfaced as a result of the way he was treated by his superiors following a physical injury. Damien sustained an ankle injury and recovery was slower than anticipated. Lauren stated that there was some disbelief surrounding Damien's accounts about his recovery. Following numerous meetings with superiors, Lauren said that Damien was told, *'you are basically lying, we don't trust you in this department anymore'.* She elucidated:

> *...the way that he was spoken to, that this is where all of his issues have come from, which is understandable, he come out of that office crying. Like they made him feel so bad, he is not a man to cry, he didn't even cry at the birth of my kids or on our wedding; you know he's not a sensitive guy and he come out of that office crying.*

Emotional and physical responses

As can be seen in Lauren's quote above, very often, emotional and physical behaviours are intertwined with each other; with a physical response (for example, auditory, visual, sensory or environmental) manifesting from a given experience or emotional suffering. Within this subcategory, the initial emotional and physical responses of the serving partner - as observed by participants - are explored. There is acknowledgment, however, that as the mental health issue developed, more behaviours and responses became apparent to participants; these are explored in the subcategory '*living in the midst of it all'*.

The initial responses that presented as a cause for concern for the participants manifested in a number of ways; namely, night terrors, crying, increased alcohol consumption, and revisiting their active duty via the media.

Night terrors causing sleep disturbances on return from a tour and, as a consequence a mental health issue such as PTSD, are well documented (for example, Nayer et al., 2013; Asnaani et al., 2014). Sara described being woken by Tom's night terrors following his tours of Afghanistan in 2008 and 2009:

> *He couldn't function in a normal manner at all and then, it was more when he got back. He would wake me up in the middle of the night and his eyes would be open, but he would be asleep, and I remember him shouting at me; like 'we need two helmets, we need them, we need them now' and I'd be thinking 'what the hell?'*

Sarah recalled how Tom would find it difficult to go back to sleep, leading to them both having disrupted sleep. Sara described how her father also had PTSD resulting from his army experiences. Her concerns about Tom, therefore, had arisen from her recollection of her father's PTSD in her childhood. She explained:

> *I had seen things with my dad but didn't experience it first-hand until Tom so that was quite difficult.*

Other participants observed responses in their spouses taking place during an awake state; these could be attributed to a continued state of hypervigilance (Nayer et al, 2013; Asnaani et al, 2014), whereby exposure to a loud bang or a sudden surprise in everyday situations were perceived as threats. Cathy identified an auditory link to previous deployment experience in her serving partner, in his case, responding to sudden loud bangs:

> *There was something that did used to trigger it for me where I knew there was an issue ...it was a warm day and he was laid down on the couch and the door slammed and he hit the deck and went to the floor, 'erm a car backfired, and his legs went. Even now, to this day, that still affects him or a balloon, he can't be near a balloon, balloons for him, he can't cope with it at all.*

Sara and Vikki described a combination of visual and auditory links which triggered a physical response; in one episode Sara explained:

> *We go to the cinema, and we have done it in the past, we've been and there will be a gun scene and he's there cowering in the aisle and [whisper] I'm like 'what is going on?'' And it will be just certain things, fireworks he's ok with but I think it's because he's expecting them 'cos if there is suddenly a loud bang or something like that, he's on edge straight away.*

Similarly, Vikki shared:

> *We had gone to Asda and got a balloon and I had, had like a little car at the time, and I had put the balloon with the weight in the back seat but, as we got the shopping out, I'll never forget this, but as we opened the boot, and the balloon came out. But the weight kept it in the car, and he just hit the deck and I thought 'what on earth is the matter with you?' like what would make you do that, but then obviously you are thinking of where he has been on high alert, if you like.*

Crying was also identified as a physical response which caused concern for Christina, Harry, Cathy and Lauren. Harry described the times when he found Nicole:

> *...just in a ball and crying and she just couldn't really work out why* or *just lying there crying for no reason and thinking 'I'm a burden, I'm a whatever'.*

Whereas Lauren stated that Damien:

> *...is not a man to cry, he didn't even cry at the birth of my kids or on our wedding; you know he's not a sensitive guy.*

Consequently, Lauren became concerned when Damien rang her from work:

> *...and he was crying. I don't know what happened. He rang me up crying and he just said I've had enough of this… I was like 'what the hell?' Just panic.*

Cathy's concern about her spouse arose years after his return from tour, at a party when she had arrived late; she stated:

> *I turned to Adrian, and he was just like a mess crying his eyes out, like uncontrollable crying.*

Evidence of the serving partner's despair and psychological battle as they tried to understand their own mental health issue or to express their feelings to others became apparent to Simone, Lauren and Harry. Lauren remembered one time when Damien rang her:

> *He rang me up crying and he just said, 'I've had enough of this; I can't do it anymore' and I said, 'well what do you mean by that?' and he went 'I just can't do it anymore' and then hung up on me.*

Simone described how her spouse went further; James' despair shifted to sheer desperation, and, at one point, she recalled, '*he's tried topping himself, he's done all sorts where he's like lost the plot'.*

As well as physical responses, participants described other behaviours displayed by their serving partners which caused concern, such as anger and aggression. Christina, Simone, Sara and Sophie spoke of such behaviours in their spouses - none of which were present before the mental health issue began. Christina's description of her partner's anger encapsulated the others' experiences:

> *It's not just that it's the anxiety and the depression, he gets angry with it as well, like the bursts of anger come out of nowhere and I'm just like 'oh my god, like what the hell?'*

Since the consumption of alcohol is prohibited during deployment, on returning home it is not uncommon for serving personnel to drink more alcohol than is usual for them, for a period of up to a year (Fink et al. 2017). Nevertheless, as with most behaviours displayed in the later stages of the emotional cycle of deployment, they should, ultimately reach a similar level of alcohol consumption to the non-deployed population (Fink et al. 2017). For those who continue to drink, excessive alcohol consumption could be indictive of emotional numbing; using alcohol to numb their feelings. For Lindy, Simone, Sara and Vikki, their spouses' continued overuse of alcohol beyond the period of adaption was indicative of concerning behaviour and change. Lindy and Simone identified that their serving partner was drinking alcohol at home on a daily basis; Simone typified the experiences of them both:

> *...he would be drinking every night, but he'd come on a night and would be drinking, every single night, not loads but he would drink every night, whereas that is not normally what he does.*

Whilst Simone and Lindy's spouses drank at home, Sara and Vikki's concerns arose from their partners leaving home to drink excessively. Here, Sara described partner Tom's excessive alcohol intake:

> *He ended up going off the rails, he ended up getting arrested for being [drunk]... he'd gone out, for drunk and disorderly, he just wasn't functioning like a normal person.*

In addition to alcohol intake, other behaviours of concern presented themselves. Lindy and Sara observed their serving partners constantly looking at and sharing graphic photographs from their tours and constantly watching war programmes. Although arguably, such an interest in the military might be expected because of their partners' career choice, the excessive revisiting of such media was a cause for concern, as Lindy explained:

> *He just spent the time showing us all these photographs* (pause) *so it was if he couldn't, didn't know what was appropriate and what wasn't appropriate, and we were all in a bit of a state of shock so we all just and he'd kinda go look at this stuff really. When the war movie channels were*

> *on, he used to sit and watch that all the time and he reads a lot of war books, he doesn't read novels.*

Empty shell

Changes in a partner's personality as a result of a mental health issue and its impact on the intimate relationship has been noted in the literature (see chapter 2). Personality changes are especially noticeable through difficulties in communication, avoidance and long-term withdrawal of the person with a mental health issue - difficulties which might not be present prior to the mental health issue. These difficulties can then lead to emotional disconnect within relationships (Woods, 2010; Renshaw and Caska, 2012; Thandi et al., 2016; Waddell et al., 2020; Brickell et al., 2021) as reflected by participants in my study, with some feeling that they were living, as Lindy described it, '*with an empty shell*.'

An element of emotional disconnect from the relationship led to the realisation for all participants that there were emerging mental health issues in their serving partners. '*Ambiguous loss'* (Dekel and Monson 2010), whereby military spouses have a sense of their serving partner '*being there but not there'*, was evident for Vikki as she described the difficulties in communication here:

> *I'm like saying it but he won't listen and that's the thing you know he will answer back but he doesn't, he does listen, but he doesn't take in what you are saying like you could be saying 'there's a car coming, there's a car' and he would be like 'stop shouting at me' and then he's dead, you know what I mean?*

For Cathy, although there had been some emotional disconnect by her partner, it was not explicit. She was unable to say exactly how the feeling of emotional disconnect manifested but expressed it as a general feeling of uneasiness. Cathy noticed that Adrian had an element of withdrawal; he remained physically present and observed events and people almost from afar, without getting involved:

> *It was nothing obvious about Adrian, it was only that he never showed any form of any emotion from anything... I always knew that when he was with us that he would generally just sit and watch a lot, it was almost like, he needed to see everything, but for me I don't know, it just felt a bit uncomfortable.*

Whereas for Christina and Simone, the emotional disconnection came from the explicit lack of conversation or indeed, no conversation at all, which was distinctly different prior to the onset of their serving partners' mental health issues. Simone described James' lack of communication as progressive throughout the day:

> *Morning time on a normal day he would be fine but then when he came home on a night there would be no conversation… it's more like you'd come home and not have a conversation or he wasn't all there.*

Simone elucidated by sharing that on the bad days, James' withdrawal was significant, and involved not just an emotional withdrawal through lack of conversation, but also a physical withdrawal; he seemed to be unable to participate in anything. She said:

> *He will have really bad days where he just won't get up, he just won't do anything, he doesn't want to do anything, can't get no conversation out of him, he won't want to do anything.*

For Christina, the lack of communication was compounded further because Daniel lived away from the family home, on a camp in another area of the country. They would phone each other every day; however, during some calls, Christina said:

> *He would ring and he just wouldn't speak, and I would be like 'what you rang us for?' And that happens still now, he'll just ring and be totally silent.*

Whereas for Lauren, it was the adverse side effects of Damien's initial treatment for his ankle injury that highlighted the lack of conversation; Damien was prescribed strong painkillers. She explained:

> *...when he would take his tablets, that would make him so bad like – you couldn't have a conversation with him, you couldn't hold a conversation with him 'cos he was so drowsy.*

The injury and subsequent work stress were the initial catalysts which led to Damien's mental health issue. Even prior to his diagnosis of depression, communication difficulties between them had intensified; Lauren observed:

> *...how withdrawn he was* and *how vacant someone could be 'cos their going through, going through their own personal stuff.*

For Lindy, while she acknowledged that her partner had sometimes withdrawn and become emotionally disconnected over the years, it had deepened and intensified over time. She described how:

> *...in the last three years (pause) I would say, he just disappeared even more I think* (long pause)

and that

> *The level of correspondence and communication, sometimes I think he treats me like a secretary, and he sends me emails and then he will say we have talked about it, and we haven't* (pause). *He did send me one today about this hotel and he just put 'please read' he didn't even spell please properly it was 'plse', you know so it's very very minimal and very little contact... he works every which way not to feel anything* (long pause) *so I would say, I am with this empty shell, and I have become more of an empty shell because of it.*

A noteworthy point for consideration, is not only did the participants describe their partners as '*empty shells*', but the impact of this emotional withdrawal on some of the participants, led to them becoming an '*empty shell'* as well. This is evident in the subcategory's '*rollercoaster*' and '*mood hoover'* below.

Living in the midst of it all

Living in the midst of it all, refers to how the participants found themselves living alongside their serving partner and the words and texts provided below are illustrative of the day-to-day experiences that ensued. The NVivo word cloud was useful to capture key words and text used by the participants (figure 13). noteworthy observation within the word cloud, is that amongst those that are predominate, are words such as '*good days'* and '*support*' indicating that being a military spouse is not always a negative experience.

Figure 13: Nvivo word cloud

As the participants moved on from those early observations and the realisation that the changes in behaviour extended beyond adjustment, the continuance of observable cues meant that they were *living in the midst of it all*. The experiences of *living in the midst of it* all prior to any action or resolve from either themselves or their serving partner was evident in all accounts. Cathy captured this in the following quote:

> *I always put that down to the fact that he had been away for 6 months, and I never really put it down to the fact that there was a change to his personality, there's a change in his personality. I don't think that came until much later on 'cos that first instance you are getting used to someone being in the house, so you know doing stuff differently, doing it different to the way you do it. Yeh so as much as, as much as I could see a difference it didn't, I just assumed it was that at the time. So, I think it was more as time has gone on, that that never left and you sort of think 'ok, so this is not the person I met.' 'Erm he's a lot different to who I originally... see, 'cos when I first met him, he'd never done a tour.*

As mentioned earlier (The beginning) the recurrence and longevity of the serving partner's mental health issue very often is what moved participants to recognise the disruption and changes on the relationship. This category explores the impact of the disruption and the changes on the participant, their relationship with the serving partner and the family unit. This is the largest category from the stories; incorporating six subcategories: the *rollercoaster, mood hoover*, *work life, and then there's the kids* and the *'good'* days. Each is now described in turn.

The '*rollercoaster'*

The trajectory of a mental health issue can be hard to predict since people can experience repeated episodes of illness at any point over a lifetime (Frank et al., 1991, Burcusa & Lacono, 2007, Green et al., 2013). Such episodes present in amongst periods of remission before relapse and recurrence again (Frank et al., 1991, Burcusa & Lacono, 2007, Green et al., 2013). Christina likened living with someone going through this to being *'just like a rollercoaster'.* Not only was Daniel's mood '*up and down'*, but the impact was also felt by Christina herself:

> *I feel really gutted when I see that he's in one of those, I don't think it's an episode, it's a mood or whatever ...gets that turmoil of emotion, that's how I know when it's coming and then I just sort of go in autodrive… and really, Daniel just needs a good talk down, and once you have a good talk down with him and the afterwards, he's all full of 'oh I really needed that', he's all like a bit calmer.*

Harry recognised a similar pattern with Nicole's post-natal depression:

> *...there's a long time where coming home every day even though I am getting away as quick as I can, I don't know what I am coming back too, I don't know whether, little things like I don't know whether she's made some dinner or I've then got to come in and do it, which is I do most of it anyway but, or if I'm gonna walk in and she's just gonna give me Sophie and say 'here I'm done or come in' and she will be fine and then she will just break down.*

The periods of remission vary between a few days to weeks or months and are dependent on the type of mental health issue (Burcusa & Lacono, 2007). For Simone and Sara, the ratio of remission and recurrence fluctuated; Sara described the periods of mental ill-health in her serving partner as lengthier episodes with longer periods of remission:

> *...it was like bouts of, he would be extreme from being happy to then like couldn't function. But he would start with really random behaviour and then he went completely off the rails, and I remember, we went through a period of like stability where he started to level out again but once a year, at least once a year he would have a bout of like 'erm it was almost like, it was weird, it was always about August time, and he would always just completely go off the rails.*

Whereas Simone's account focused on daily episodes:

> *He can just have one bad day. Don't really go onto next day, I don't think so. I think when he went through his real bad stage, he had more bad days than good days. Sometimes it felt like every day.*

During the second interview, I asked the participants '*How are things now*? While the majority of serving partners were then in a period of remission, there remained some degree of trepidation on the part of participants; they felt that their serving partners' mental health issues never really went away. Sara acknowledged how James' mental health issue ensued all aspects of life; she described how:

> *...even now he struggles with big life events, it's a real worry if something were to suddenly change*.

Christina acknowledged that because of Daniel's mental health issue and her feeling that it would never really go away, she had to adapt to it. She changed her behaviour and responses towards Daniel which, subsequently, meant that the relationship as a whole changed. Despite the adaptations made by Christina, struggles still existed. She captured the overall sentiment here:

> *I don't think Daniel's anxiety, depression is any better than it was when he left [the army]. I think our relationship is better and I think I'm, I deal with it better…… it's a, it's frustrating, I can't describe it, at the minute, the past year has been like a seesaw, like he's pushing but then I'm pushing back, we're not, not working together*.

The *'mood hoover'*

As the '*bad days'* mounted up, the impact of the serving partner's negative behaviours eventually took their toll on participants who then began to experience negative moods themselves. Lauren, Sara and Sophie explained how the overall atmosphere changed for the worst on a bad day. Sara described Tom as a '*mood hoover'*:

> *I think he's kind of the best way to describe it is he can take the atmosphere, the nice atmosphere away, I would say like a mood hoover. Like it literally, just drains it off everybody.*

The participants' mood was impacted when realising their serving partner was having a bad day, either by being low in mood or through extreme behaviours. This was captured by Simone, Christina and Lauren. Simone typified this realisation when she explained:

> *Straight away I'm in a mood. Yeh straight away 'cos I think 'yeh great this is what the days gonna be like', you can't get him up. You can't get him to talk, so yeh, I get quite arsy and then it ends up in an argument generally.*

With a change in atmosphere came an increase in arguments. Arguments were noted by Christina, Lindy, Simone and Lauren. Simone summed up the ongoing situation by simply stating, '*there was quite a lot of arguments.'*

As opposed to the arguments which Lauren suggested were generally over 'small things', Lindy, Lauren, Sara and Vikki felt that often, they received the backlash from their serving partner if their partner had experienced a bad day. There was a general feeling that their serving partner's mood was often taken out on them, sometimes through – they felt - no fault of their own. Vikki typified this in her comment:

> *...obviously, like normal, we get all the backlash. So, if somebody has had a go at them, then nine times out of ten it's us.*

As did Lauren:

> *...he has a really bad day, then I get it in the neck, so I'm just like 'great!'*

The use of '*us*' in the quote above suggests a sense of commonality and comradery between military spouses; indeed, this sense of being in it together, can be seen in other quotes from Christina, Cathy, Sara and Sophie throughout their stories (Chapter 3, 4 & 5).

Although the '*mood hoover'* effect initially appeared to have a one-off impact on the participants, what was clear from their stories – as heard as a whole - was its lasting impact. The lasting impact of such an emotionally unstable environment, caused emotional reactions in the participants. While there are some shared experiences and reactions, their serving partners' mood affected the participants in different ways and to different degrees. *Living in the midst of it all,* brought a myriad of emotions felt by the participants. The depth of Cathy's unhappiness was evident when she stated,

> *I was just so deeply, deeply unhappy, like really unhappy.*

Feelings of frustration were common in many of the stories. For Harry and Simone, frustration was the overriding feeling:

> *I think the biggest one is, it's frustrating when, after she had started getting treatment and even before it, it's frustrating.*

For Simone, the constant change and unpredictability in James's mood and how it made her feel led to frustration; she revealed it was,

> *frustrating, really more than anything.*

Sophie, however, felt anger as well as frustration,

> [*I feel] frustrated and angry as well.*

Indeed, anger featured heavily within participants' accounts. A great deal of the participants' anger appeared to derive from their serving partners' extreme behaviours; for example, extra marital affairs (Lindy and Sara) and excessive drinking (Lindy, Simone, Sara) which had a huge impact on participants' moods, as Lindy explained:

> *He has pushed me and done stuff to make me angry in a way I have never been angry with anybody else.*

Anger also resulted from the serving partners' emotional withdrawal. For Christina, her anger arose from Daniel not sharing his emotions:

> *I was just angry, really angry that he wouldn't open up properly.*

For others, the emotionally unstable environment and the unpredictability of mood changes made the participants feel '*on edge'* or hypervigilant. For Sophie, the unpredictability of her partner's mood changes made her feel:

> *...tense and just hunched over waiting for something to happen, something to set him off.*

Whilst Sara and Vikki summarised the feeling of being on edge with the unpredictability of their serving partners' mood as being like 'walking on eggshells':

> *It makes everyone feel on edge really, makes me feel anxious. I'm like on eggshells.* (Sara)

> *A nightmare, I wouldn't dare speak, like walking on eggshells literally.* (Vikki)

The emotionally unstable environment, coupled with the unpredictability of mood changes, brought about in participants a constant underlying worry about missing the signs of recurrence of their serving partners' mental health issue. Christina and Lindy questioned themselves, with Christina stating:

> *I feel like I get ultra-sensitive, get lulled into thinking 'everything is ok' and it can be ok for days, weeks even and then like you said, and I just think, 'oh my god have I missed the signs, has this been brewing for ages, where's this come from'?*

There was a further worry which was present regardless of remission or recurrence; one of self-harm or suicidal ideation. Suicidal ideation and a range of predictors are recognised in a plethora of military studies (Jakupcak et al., 2009; Pietrzak, et al., 2010; Maguen et al., 2011; Gradus et al., 2013; Wisco et al.,2014). Gradus et al. (2013) and Maguen et al. (2011) have identified that deployment stressors along with post deployment mental health issues are significant predictors of suicidal ideation. All participants expressed this fear; Vikki's quote below illustrates the day-to-day turmoil of worry about whether their serving partners' thoughts were of self-harm or taking their own life:

> *It's like when you are just at work and hear on the news about a train incident knowing what mood you have left them in and stuff like that, you don't know if it is them or not. If they are that way and then they turn round and sort of say I would never be that stupid to do it, but you just don't know do you?*

For Simone, the fear became a reality when James tried to take his own life. Simone shared:

> *…it's just horrible,….at Christmas ……that was when he tried topping himself, he got took to hospital, his mam took him to hospital, …..I didn't know what he had done at this point and then the Dr ringing me from the hospital saying it had happened.*

As well as feelings of anger, frustration and worry around their serving partners' unpredictable mood changes, an overriding feeling of exhaustion and tiredness also prevailed. Lindy and Simone both spoke of their exhaustion. Simone described the relentlessness of each day:

> *Sometimes it felt like every day……. I thought I don't want to have to deal with this every day*.

Lindy summed up the years of living alongside Craig's mental health issue:

> *I'm just tired of it all………. I had no idea; it's just been relentless really.*

Whereas some participants spoke of the loneliness and/or the helplessness that they had felt during their serving partners' mood changes:

> *It's been mostly lonely* (Lindy).

> *It was quite lonely* (Simone).

And Christina stated: *It was just horrible, felt totally helpless.*

In summary, Cathy's quote below encapsulated the movement between the range of emotions felt by participants:

> *I had a mixture of emotions, I would be frustrated, then we would have a row then I would get angry, then I would go from being angry to feeling bad.*

Work life

For some participants, the constant strain was also felt in other aspects of their lives, such as work. At the time of the interviews, all the participants worked. An impact on work life was felt by Christina, Lauren and Sophie, who found that worry about their serving partner was a distraction. The distraction for Christina was useful in some ways as she had just started a new university course:

> *It was just horrendous, I didn't, I wasn't even worried on my first day of uni' 'cos I was too busy thinking about him. ...in a way, it distracted me from here, so I wasn't nervous on my first few days here and I didn't really, not that I didn't really care it was just that I was drifting 'cos I was constantly looking at my phone and that's not like me, I was ringing him, but I was so distracted from here for my first month I would say 'cos me head was down*

> *there, even though I wasn't there… If I wasn't on this course, I would have put some leave in whatever job I was in and went down there.*

For Lauren, the distraction was more negative; fear of being pulled away from work to attend hospital with her serving partner - something which had happened to her on a number of occasions. She described:

> *...there's been times that he has called my work with chest pain, he's had an ambulance sent out and I've had to come home and then for us to go to A&E.*

Asa result of Damien's low mood and emotional withdrawal, Lauren also described the worry of leaving the children with Damien whilst she went to work:

> *Even the way he was like, how withdrawn he was, like what if they hurt themselves and he doesn't realise 'cos he is so like focused in his brain, I had to go to work with a fear of like leaving them, not a fear of leaving them with him, it's concern, like I just thought that 'what if one day he's like he just thinks I've had enough of this and thinks of going to do something?' Like 'cos you don't know how mental health affects people.*

Simone and Harry also experienced worry and fear; fear of what they were going to come home to after work. Harry summarised this:

> *I think it does have an effect at work 'cos you're 'erm (pause) ultimately, everything else kind of isn't really that important. I think, I, I, didn't really miss, I have never missed anything or had any issues at work but there's definitely, just all the time, you are thinking about when, 'what am I going to come home to'?*

In contrast, Simone and Cathy saw their work as an escape. Simone stated that she:

> *...would just look forward to going to work to get out away from him but then I hate the thought of coming back again 'cos of just like how he is.*

More positively, Cathy described how she had found a job when her relationship with Adrian was failing as a result of his mental health issue. She shared:

> *I just tried to make a life for myself really and let him do what he was doing, and I just make my own friends, my own fun and a job, got myself a little job.*

And then there’s the kids

As well as the impact on work, for those who had children, the effect on them was notable to participants. Despite the age ranges of the children, participants described the impact on all - except for Harry’s children - who were pre-school age. Lauren, Cathy and Sara’s children were primary school age or younger. Cathy explained:

> *...he’s suffered with the life Charlie.... Grace I always go ‘she’s as tough as old boots’, she acts like she is but actually she’s not, she’s very secretive about her feelings though, ‘erm whereas Charlie is like me, wears his heart on his sleeve so but he’s now currently going through, he has to have play therapy ‘erm at school, we are still waiting to hear back when that’s gonna take place and I am waiting for the doctor to refer him to a paediatrician just because he suffers from anxiety and panic attacks and he has since he was three years old. We didn’t know at the time that he was having anxiety and panic attacks at the time and he just, to just say ‘mummy I think something bad is going to happen’.*

Whilst Charlie’s responses to his father’s mental health issue included physical symptoms, for Lauren and Sara’s children, there was commonality in that, on the bad days, the moods and/or the atmosphere put them on edge which then, in Lauren’s words, made them ‘*play up’*. Similarly, Vikki and Sophie felt that their teenage children were ‘on edge;’ Vikki summarised the impact on her children:

> *It's just like psychologically, what that does to the kids so, where they don’t even feel safe in their own house, you know.*

By the time the children reached adulthood and left home after years of exposure to the serving partners disruptive behaviours, they could choose whether to return to see their parents. As Lindy explained:

> *The kids would find now that they are older, there has been times where they have not wanted to come home because they know there is an atmosphere, they know when things aren’t right, and they just don’t want to be a part of it.*

The impact on the children, led to Lauren and Sara questioning themselves. Lauren and Sara felt torn between their serving partner and their children; however, for both Lauren and Sara, the welfare of their children was overriding. Lauren stated:

> *As much as I love him, like and I want to support him through everything, like I've still got two kids' welfare to think about.*

For Sara, because of Tom's mental health issue, there was a conscious decision to not have any more children:

> *...we knew we weren't having any more children I wouldn't dare take the risk and I can cope well with Jack if Tom was to go off the rails again, I know that I can pick Jack up and we could go and things would be absolutely fine. But I know if I was to have more than one or to go through that stage again, it would just be too much of a shake up and there might be resent there 'cos he definitely doesn't want any more children.*

Cathy felt that the negative experiences her and Adrian were facing were situated in their relationship, not their relationship with their children:

> *There is nothing in this relationship apart from the children and we are staying together just for the kids……. he was just, he was just the father of my kids at that point.*

Cathy said that she remained in her marriage for the children. Despite the problems that Charlie had, Cathy felt that he had a strong relationship with his father as did Grace:

> *I only stayed really for the children. I wouldn't, he knows that I would only stay for the kids... I think, just purely, that I know what it's like to grow up in a, with separated parents that I just couldn't do that and they, they adore their dad. 'Erm so yeh I just couldn't do it to them.*

It can be seen from the quote above that Cathy's 'own experience of growing up as a child of divorced parents made her determined to keep the marriage, and the family unit, together.

The '*good*' days

As mentioned earlier in the chapter, there are often periods of remission where participants and their serving partner experience an element of stability and normality in their relationship, akin to times prior to their serving partners' mental health issue. This is predominantly when the serving partner is mentally well. The participants talked about good days and times. As Harry pointed out:

> *...there were days when you get in a good space… where it was just mainly, she was laughing, or she found something funny or was spontaneous or do something silly.*

For Simone, Lauren and Sara, the good days were very much dependant on the emotional state of the serving partner. So, if the serving partner was positive and upbeat, then they were too. Simone typified the sentiments felt by Lauren and Sara when she stated:

> *'Cos if he's positive, then I'm positive, like I say, we would have a good day, if he was good, I was good……Great, yeh, I think, think 'nice one' yeh. 'Let's go do something'. Yeh, when he is having a good day, it's a great day. We get on real well, we will go do something, yeh we will have a real good day when he's having a good day. Yeh.*

Satisfaction with their life and marriage was evident for most of the participants and continued to be felt as they expressed gratitude about the good days and how happy these days made them feel. For Christina, Simone, Vikki and Sophie, a good day when was when the environment felt *chilled* and *relaxed.* Sara saw the times when Tom was mentally well as perfection:

> *Oh, it's great, I feel like everything is great, like kind of perfect… relaxed, it makes me feel a lot calmer I'm not walking on eggshells……when he was in a really good mood, been taking his medication like correctly and everything is great. He was really relaxed, not on edge, not like over tired or anything and I feel like when he is like that, he's great. When he is great, he is perfect.*

When Damien was mentally well, it took Lauren back to the time when she first met him; she stated:

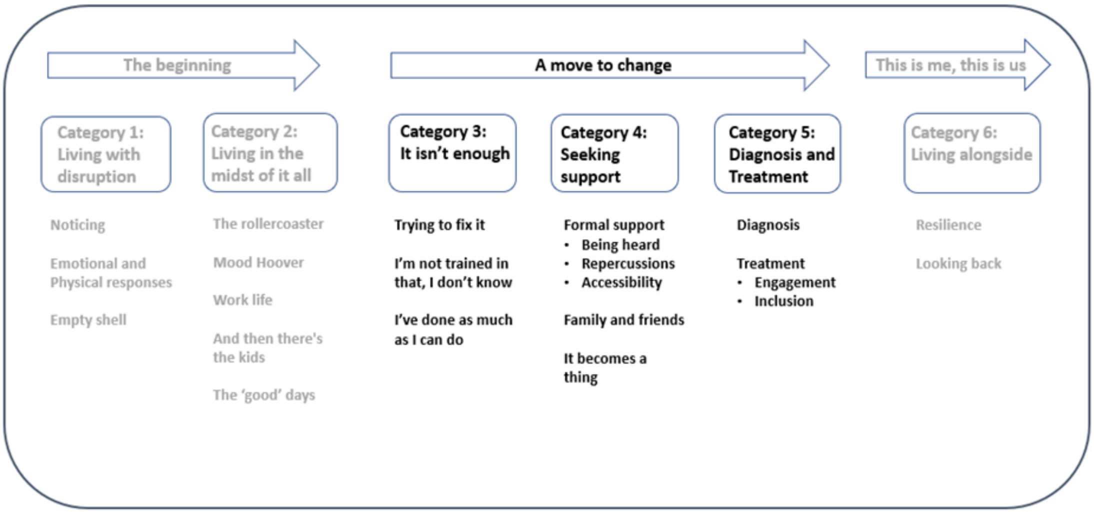
> *It's nice. It reminds me of when I first met him and you know it's just like, how happy he is… It just makes me feel good then 'cos I'm like you know if you got a happy person in the house, you actually become happy don't you, erm yeh it just makes you naturally happy and the kids naturally happy and then we are all happy together.*

The extracts illustrating good days or times is almost the reverse of the 'mood hoover' and what is consistent throughout is that for the most, the participants are reliant on their serving partners mood to determine their own mood or prediction of the day either good or bad.

6.3 A move to change

As highlighted in chapter 1, mental healthcare provision for UK serving personnel is provided in-house by Defence Medical Services (DMS) whose services are aligned to and delivered, following the same policies and guidance as the National Health Service (NHS). It is widely accepted throughout the NHS that the inclusion of the family in the treatment of a client with a psychological illness can aid recovery and provide vital support in managing the condition for both the client and their family. Such provision is documented in NICE guidelines (2005, 2011, 2014, 2015) which explicitly reference family involvement and the requirement of been given written and verbal information regarding diagnosis and treatment, positive outcomes and recovery, support for families, the role of the teams and services involved and how to get help in a crisis. This inclusion is mirrored in the majority of Mental Health Trusts who provide specific families policies which also promote family inclusion, the need for domiciliary visits, family input and joint working (for example, Tees, Esk & Wear Valleys NHS Foundation Trust, 2014). As DMS mirrors the care provided by the NHS, it could be assumed that families would be supported and be included in the care during a serving partners' mental health issue. Figure 14 illustrates the categories and subcategories for this section of the journey: A move to change.

Figure 14: A move to change



This part of the journey describes a move to change in terms of the participants' situation of living alongside their serving partner with a mental health issue. It signifies how the participants tried to 'fix' their serving partners' mental health issue and, in some cases, their marital relationship. It also explores the participants, and their serving partners' attempts to seek and receive help. Participants talked about experiencing frustration, the varying avenues of support - both informal and formal - that were available to them and their serving partner, together with the treatments received and any inclusion of the military spouse during the treatment episodes. Participants described episodes that they observed, consultations they attended with their serving partner and/or where their serving partner relayed information from the consultation to them. Three categories were generated: it isn't enough, seeking support and diagnosis and treatment.

It isn't enough

A common category from all the participants' stories was an inherent need to 'fix it'; 'it' being either their current situation of living alongside their serving partner with a mental health issue or the mental health issue itself or both. Whilst participants felt that action was required to determine a resolution for the mental health issue, central to this was a blend of feeling the need to help and needing the knowledge to be able to help which, for most participants, led to them feeling that their help, support and interventions were not enough. Three subcategories were identified; each subcategory uses direct words from participants:

> *trying to fix it, I'm not trained in that, I don't know,* and *I've done as much as I can do.*

Trying to fix it

A strong commitment to their serving partner was evident from all the participants' stories. From living in the midst of it all, there were initial movements towards trying to fix their serving partners' mental health issue. The desire to 'fix it' was from an emotional and physical perspective and differed between the participants. Sara captured the collective feeling:

> *I often think and wonder if I just wanted to try to see if I could fix him, it is weird.*

Sophie, too, explicitly voiced her need to '*fix it'*. She shared the conversation she had with Nathan:

> *[I said] 'Well, just tell me what's wrong?' 'I can't fix it if you can't tell me'.*

Some participants voiced that they felt an actual need to help, as well sensing their serving partners' reliance on them. Christina, Simone, Sara and Sophie, identified this need to help as maternalistic; with Christina and Sophie recognising that they wanted to do everything they could for their serving partner in order to 'fix' their mental health issue. This was highlighted by Christina:

> *I have always been like a mum, like I have always mothered him... like motherly, just want to help him, I literally would bend over backwards for him.*

Sara's maternalistic instinct was to protect and prevent harm and was influenced by her childhood experiences with her father:

> *I didn't want Tom to fall down the same route that my dad did so that was quite tough.*

Whereas Harry viewed the giving of help to be more practical by keeping everyone and everything running smoothly:

> *...she feels like she's not really, you know, been around or done anything. and 'er she thinks that 'erm I've been kind of keeping it together which is, which is true 'cos I have been doing.*

Simone's way of trying to 'fix it' was practical too; she thought that the situation would improve if she and her partner moved away from army accommodation and bought their own home:

> *I thought it would help getting out of there, obviously getting our own place and he got put through his discharge and I thought things would get better, but they haven't really.*

I'm not trained in that, I don't know

As highlighted earlier, it is widely accepted that services promote the inclusion of families so that they can gain knowledge and understanding of a given mental health issue; how and when to intervene (NICE guidelines, 2005, 2011, 2014, 2015, 2021). All participants recognised knowledge and understanding, or the lack of it, as a noteworthy point within their experiences; however, none were offered education, information and advice from the DMS or from other avenues of support.

Lack of knowledge and understanding about mental health issues was highlighted by many participants, leading to the feeling that they - or what they could offer - was insufficient; Lindy simply stated, '*I don't even know what would help'.*

Lauren felt that her lack of understanding was exacerbated as a result of not being trained to recognise and deal with mental health issues:

> *I thought, 'I'm not trained in that, I don't know' and yet I knew there was something not right with him… This is the thing, I don't understand it enough to be like 'oh I understand why you are in a mood' so like, you know, and he'll be like 'I'm in a mood over nothing' sometimes, and I'm like 'how can you be in a mood over nothing?' – I don't understand it.*

In contrast, Harry felt that he held a reasonable level of understanding of Nicole's post-natal depression:

> *I'm quite, I'm pretty sensible and it's that thing 'cos I am a science teacher and I'm relatively medically, we both understand through whatever means and training we both sort of understand what's going on cos that's half the thing.*

However, he found it hard being unable to understand or make sense of the triggers that led to Nicole's breakdowns:

> *You don't know what has triggered and that the hardest bit, they don't know …. she doesn't know and the hardest bits has been when was trying to sort of catch what had started her getting cross or getting upset which, and you really can't work out why, is it just because she has just thought of something or she's looked at a situation or she's seen the kids being really happy or and then that's just sort of triggered something 'erm and I think it's just the (pause) kind of I don't know, it is that it was just the frustration of not knowing.*

Sophie shared Harry's frustration but felt that her inability to understand was due to Nathan being unwilling to share:

> *[It's] just so frustrating, 'cos he doesn't tell me when something is bothering him either, so it's the, it's, it's your minds going ten to the dozen wondering why he is in a mood, to what has put him in that mood and whether anything*

> *you've done has put him in that mood and like it's, it's constantly trying to over think what's, what could possibly put him in the mood in the first place to try and fix it.*

In contrast, Simone's spouse, James, did attempt to reach out to her by sharing a video clip he had found to help her understand him better:

> *James showed me this video and he was 'just like have a look at this'… he said 'just have a look at this video of this guy'. Eventually, this guy did kill himself 'cos he just couldn't cope anymore and he [James] said 'that's how I feel, but that's like how I feel' and he had to do it through a video to show me.*

Following this episode, Simone initiated the move to increase her knowledge:

> *That's when I had to speak to his doctor and said I wanted him to go see counselling or whatever so I could understand a bit more about it.*

Christina also identified the need to increase her knowledge but did this independently by researching on the internet:

> *I remember once I'd seen this thing on the internet and I don't know if you might of heard of it, it's like depression depicted as a black dog, the big black dog sat on your chest and it gets bigger and bigger (tearful) 'eey I'm getting upset again, and I remember, he I showed him this and he was away and I sent him the link and said 'read this' and because it's interesting reading and he read it I remember he was like a child ringing back and saying 'oh my god that's so me, I have a black dog that sits on my chest all the time'.*

Participants revealed that knowing *when* they should intervene during a mental health issue could be a challenge if they lacked the relevant knowledge and understanding. This made them feel uncertain about whether intervening was the right thing to do. Christina, Lauren and Simone all at some point tried to intervene and provide some support to their serving partners but found themselves questioning their usefulness. Christina illustrated the collective feeling:

> *I felt like, as much as I'd tried so hard, like support and help, it's like it wasn't enough, like it wasn't enough.*

As Christina highlighted in her story (chapter 5) in the early years of the relationship, Daniel was based away from their home. Christina moved house to be with Daniel in order to support him during a recurrence of his mental health issue. She recalled the move and wondered:

> *I don't know if that helped, me being with him or whether that sort of I don't know fed an illness that needed something else. I don't know if I helped or not.*

The majority of participants felt that they wanted to understand more about their partner's mental health issue. Simone explained that because she did not fully understand, she thought James was just being difficult:

> *I would understand more and know how to deal with it more 'cos I didn't understand it, I just thought he was being like that, just be an arse.*

Lauren mirrored other participants' sentiments about how important understanding is:

> *I think having more understanding of it, like if somebody sat [you] down, like a doctor, and said, 'you know these are the triggers you need to look out for, these are the things you need to do, how you need to say it, 'cos you might be triggering him to.... how he is'.*

I've done as much as I can do!

After a period of trying to *'fix'* their serving partners' mental health issue, it was felt by some participants that they had reached a point where they had done all that they could in terms of what they knew would help them. It was at this point where participants articulated that the marriage was threatened and had started to deteriorate. Christina and Vikki, however, still felt a need to '*hang in there'* and see what happened next. Vikki explained:

> *I suppose just holding out really, clinging on to a string, waiting for that to give way… I just sort of clung on as you do, you know you don't want your marriage to break do you! You know!*

The strain felt by Christina, Lindy, and Simone became so great that they said cracks in the marriage were beginning to show. Cathy, had been unhappy for some time as she described below:

> *I was… for a long time; it took a long time, but it didn't take a long time for me to be unhappy. I was unhappy, I was unhappy actually even when I fell*

> *pregnant with Grace, I wasn't happy then so that's what two years after Afghan, that's when I probably really just wasn't happy with what, the situation and no matter what, no matter how much I asked him to sort his issues out or like to talk to me or to, you know? [I] tried all different ways of trying to get him, just sort of get him, to sort of say anything and it just fell on deaf ears.*

This then led to Christina, Lindy and Cathy giving their partners an ultimatum; they would leave the marriage unless their serving partner sought help or support outside of their relationship. Christina exemplified this:

> *I thought we were over… at the point now where I feel like I've done as much as I can do in the whole relationship, I wanted him to go to welfare, say that he is struggling mentally, I wanted him… and obviously eventually, he went to the doctor and sorted all that out.*

Although an ultimatum was never given to their serving partner, Lauren and Vikki talked about the desire to walk away from the marriage, taking the children with them; Vikki said it was *awful, you just want to grab hold of the kids and run away, it's that bad.*

Whilst there was no explicit timeline highlighted, it was felt by some participants that they had reached a point whereby coping with the situation had become too much. Simone typified this, *I thought, I don't want to have to deal with this every day.*

Participants expressed a desire to leave the relationship, to remove themselves from the situation; Christina simply stated, *I just wanted out, I wanted him to get out.*

For Simone, Cathy and Sara, it was their serving partners' challenging behaviours that ultimately led to a marriage breakdown and temporary separation. Cathy explained:

> *I needed someone to sort of say 'this is what's wrong', that's all I needed him to do… I detached myself really at that point... he was just, he was just the father of my kids at that point...I did leave Adrian last year, the January before I had just reached the point where I just can't live this lie anymore, I just can't do it, I haven't got the energy, I physically do it...I did split up with him, I did leave him, and he moved to the block...*

Whilst the desire to leave the marriage was voiced and temporary separations were evident, these were reversed later on and none of the participants left or divorced their serving partners.

Even when the participants were unable to '*fix'* their serving partners' mental health issues, some felt that leaving the marriage was not the resolution. Despite the disruption to themselves, their serving partner and the relationship, participants tried to rationalise why they had stayed in the marriage. Sara explained why the thought of leaving was not an option for her; however, she questioned whether it was right to stay:

> *I recognised the signs straight away, I knew exactly what he was suffering from, it was like PTSD and knew that he wasn't behaving in a normal manner and may be that is why I stayed with him because most people would have been off a long time ago, people would have just given up. There's often people who have said to me 'why on earth have you stayed, what are you crazy?' They have literally said to me 'what is it that has made you put up with this'. I often think to myself, 'I wonder if I have done the right thing?'*

Although Lindy's reasons for staying differed to Sara's, Lindy shared why she had stayed in her marriage:

> *I think I've kinda, there's a part of me that's put so much into this lifestyle that I never ever wanted that I feel I want something back.*

Seeking support

For some participants, the point at which they felt they did not know what else to do, was when the stress started to impact on the marriage. This was pivotal in encouraging and motivating their serving partner to seek external help and support. For some participants, it was also a motivator to access help and support for themselves. The importance of support was expressed by Christina:

> *It's all just a recipe for disaster isn't it when you haven't got that support.*

Formal support

Formal support is defined as any help or support offered by or received from services provided by professionals who are typically trained and paid for their work (Serva, 2014). Two avenues of help and support for the serving partner were identified by participants: medical services and welfare services; both provided by the military. For serving partners with mental health issues, it could be expected that they would initially receive help and support '*in-house*' from the DMS. DMS are aligned to and delivered following NHS policies and guidance. Ordinarily, DMS provide medical care for the serving member only, meaning military spouses have little or no access to the care DMS provide. Within the military, this void is often bridged with the welfare service. The welfare service is predominantly provided by specifically trained serving personnel and is provided for social or pastoral care of the serving person and their families.

Reaching the point where the participants did not know what else to do to support their partner was key to encouraging their serving partners to seek external help and support from outside of the family unit and friends. For Lindy, Simone, Cathy, it was recognising combat stress as one of the motivators for help seeking, whereas for Christina, Lauren, and Vikki, it was increased symptomology that led to an ultimatum. Christina, Lindy, Lauren, Simone, Cathy and Vikki all spoke of the time when they encouraged or motivated their serving partner to seek help.

Some used the veiled threat of contacting military services on their serving partners' behalf as a motivator to seek help; in the belief that other serving personnel would view this negatively and, therefore, cause their serving partner an element of worry. The extract below from Simone's story illustrated this:

> *I know when he had got quite bad in Kent, I can't remember who he had to go see and I said to him 'put it this way if you don't go and see them, I will be going in to see someone…' 'cos, like it was really worrying, like… I used to threaten coming in with him, but I didn't know what I was doing but I was 'if you don't, you know I will come in and do it' so he used to go do it. Even though really, I wouldn't know who to go to or who was where. I didn't know but he didn't know that. He would say he forgot sometimes, say 'oh yeh I forgot' and that's when I would say 'if you don't, I'll come in and I'll, I'll come and see someone or I'll come with you', and I don't think he wanted the embarrassment of me coming in and saying whatever. But I didn't know who I needed to see anyway, so I just used to threaten it… He did take notice, yeh he did yeh, which it got him somewhere in the end.*

In contrast to most participants who stated that they had played a role in motivating their serving partner to seek help, for Cathy and Harry the scenario was different. Cathy felt that despite her plea to seek help, Adrian chose not to:

> *I was just waiting really until, I had asked him to get help, he didn't… still begging him to just get help, he still wouldn't… I think coming from us as a wife, coming from you, for some reason it doesn't seem to, it doesn't mean anything.*

Harry explained how his wife, Nicole, was due to return to work following her maternity leave and recognised that she would be unable to function fully at work. While Harry had noticed the changes, he had felt it best for Nicole to come to the decision to seek help herself:

> *...she was really good, and she decided that she needed to go see somebody 'cos as with everything that's the longest bit and the hardest bit and she realised she wasn't going to be able to function back at work and so I am pretty sure she didn't go back properly, I'm pretty sure that the maternity leave kind of rolled into 'erm* (pause)*, medical leave or whatever they call it.*

Being heard

Once they had reached the point of accessing help and support, participants articulated that the next hurdle was one of being heard. A mixture of positive and negative experiences was identified in terms of the support they received from medical and welfare services. For some, the response from the formal avenues of support was positive. Christina and Sara found that the provision from the DMS was proactive and responsive to the needs of their serving partner; Sara felt:

> *The army have been good, they have supported him... he saw somebody and he had to go through like a decompression stage and then they do so many meetings after and I think they picked up something wasn't quite right 'erm and it was when I disclosed and said 'look like he is having the bad dreams, like things aren't quite right, like we have gone to the cinema and he's cowering in the aisles', 'you gonna have to do something', I said, 'like this isn't normal?'*

Similarly, participants described good support from the welfare service; however, where the experience was positive, it was only helpful for the serving partner, not the military spouse. Simone and Cathy reported that their serving partner had a good welfare experience. Simone summed up the experience of her serving partner, James:

> *Welfare was real good, he was real helpful. I know he was really helpful he was really good for him, if he needed anything.*

With the exception of Christina, Harry and Sara, the general consensus amongst the participants, was that DMS were slow to act and respond only to the serving partners' needs. In stark contrast to Sara's positive experience, the provision by DMS experienced by Vikki and her spouse, Darren, was one of apathy from an individual health professional. Vikki explained:

> *He did go in 2000, late 2003, this was at the Barracks, and we saw a psychiatrist there or a CPN or whoever he was, and he fell asleep while we were talking to him. I think it was a Monday morning appointment, I wish now I had taken a photo but obviously at the time you weren't glued to your phone, and you don't think I will record it or something like that. And he was sat there opposite us, and he was going* (head gesture of falling asleep) *and I'm thinking 'are you just like listening or what are you thinking?', Are you thinking 'oooh it's a sign of this' or 'you need electrocuting' or whatever it was, and I literally went* (raised voice) *'Are you alright?' And he went, 'oh yes sorry, sorry I've had a hard weekend and I just drove up from Cornwall'. And then started telling us about his weekend down in Cornwall…… I'm sat there thinking 'this might be funny to you, but this is my husband'. Do you know what I mean? And 'it's our life, I'm the one getting the brunt of it'.*

Similarly, Sophie spoke of a lack of concern or interest from medical services regarding her serving partner's mental health issues:

> *This was about two years from the point where it actually started but the doctor had been sitting there knowing, seeing him quite regularly for his problems with his back and things like that and not once said to him 'I think you have got a mental problem', they just carried on…Then he went to the doctor and said ''look I can't cope anymore, I don't want to be down here, I don't, I want to be home' and the doctor was like 'well I thought you were depressed' but they hadn't done anything about it.*

Nathan's mental health issues arose from stress at work; this was evident to other personnel in the unit. Nathan had become complacent, withdrawn and stated he no longer cared anymore during an overseas posting, but senior staff became annoyed rather than supportive. For Sophie, it was about the military's duty of care; how the military recognised and initiated support, diagnosis, and treatment:

> *For me, if someone from the army can see someone under that pressure, step in and stop it.*

While Sophie highlighted the need for services to step in, Simone, Lauren, Cathy, Sara and Vikki described having had some level of contact with welfare services. However, they felt that services were not focused on the family unit and were only interested in serving personnel. The overarching feeling of participants was typified by Simone:

> *They all say like they are family orientated but they are not, they don't think anything about families I don't think, it's all about them* [serving personnel].

When the participants spoke of their own personal experiences with the welfare service, they were more negative, highlighting a lack of support. All the participants, except Harry, who had no experiences with welfare services, shared their experiences. Christina, Lindy and Sophie admitted that they would feel uncomfortable accessing the service. Sophie's comment summarised participants' feelings:

> *I don't think I would talk to them anyway, I don't think, because they are like just another soldier in that role, they've not been specially trained for it in any way, so I don't feel like they would be able to give me any type of advice.*

Sophie did not want to access welfare officer support for herself in the belief that they did not have specific training. Although this is a misconception (welfare officers do receive specific training), it does reinforce participants' perception of a lack of communication and information giving between the welfare services and military families. Indeed, Sara felt that welfare services needed to do more about contacting families, rather than just expecting the families to be proactive:

> *...just a little bit more contact with the wives, bit more contact or even just ringing you up just to say, 'how you are getting on, is there anything we can do?', there was nothing like that unless you went to them. So, someone who maybe isn't as confident might struggle if you like erm they probably wouldn't necessarily know what to do or where to get it from.*

Lauren echoed this sentiment:

> *Even if they just turned round, I don't know the welfare of something and they just said 'I know your husband going through stuff and we just wanted to make sure you are ok, are you ok?' and have a cup of tea with 'cos then,*

> *even then, you can say actually 'no I'm not, no I'm not ok, I'm going to leave him and that's that'.*

Repercussions

As identified earlier, the findings illustrated that very often it was the military spouse that motivated or encouraged their serving partner to access help and support. For most participants, their serving partner did access support from DMS; however, very few accessed supports for themselves or their military spouse from welfare services. There are a few possible reasons why serving members might not access or encourage their partner to access welfare service access; for example, they might feel it is unimportant or not needed. Whilst no specific examples were given regarding disadvantages of accessing services, Cathy and Sophie highlighted a perceived a lack of confidentiality by indicating that their serving partners were worried that, to do so, would result in negative repercussions. Cathy's story showed that it was the possible repercussions in his workplace that might befall her serving partner, Adrian, that caused concern:

> *Adrian says, 'it's ridiculous', and I, when I said to Adrian, 'oh I'll phone up welfare', he said 'no, don't do that' because he's always worried about the repercussions that if I kick off or I not even kick off, if I just phone up and say and question it, it's going to come back on him somehow. I think probably it does have repercussion on them I think, I think it does depend on what their job is, like at the minute, he's on a course and they can make his life absolute hell if they had an issue.*

Lindy attributed potential repercussions on the serving partner to the perceived hierarchical positioning, whereby the officer's wife would be seen as the one to offer support rather than receive it. Lindy's reason for not seeking welfare support differed to Cathy's; as an officer's spouse, she did not want to be seen as unable to cope; she admitted:

> *If I had welfare coming to me, I would probably say I was fine as there would be an expectation to cope.*

Whilst not specific to this subcategory or indeed these findings, the expectation to cope could be a result of the stoic military culture discussed in chapter 3 and/or perceived hierarchal positioning. Indeed, the stoic military culture and perceived hierarchical positioning was evident in other participants' stories when they relayed different experiences such as helping out with childcare and support during a deployment.

Away from the formal support offered by the military, there is also non-military NHS healthcare provision for the military spouse. Although by its nature, the stoic military culture and/or perceived hierarchal positioning is not apparent in non-military healthcare provision, the findings highlighted that for some participants, the military culture still had an impact on them resisting treatment for themselves (see findings under the heading: family and friends). Despite recognising the need for therapy, Sara was reluctant to access help because she perceived that there would be repercussions in doing so, such as having her child taken away from her if she was seen not to be coping, she stated:

> *I was frightened that if I sought counselling it would go against me, or that would make me, them think that I wasn't coping as a mum or as like a unit for the family.*

Even though Sara was initially reluctant to access help because of the perceived repercussions, she sought counselling:

> *I had to seek it; it wasn't offered. I went in and explained the situation* (to military welfare services) *but got offered it then and that was really good and really supportive and then I went to my General Practitioner (GP) and I got extra counselling with my GP after as well which did help. I think my GP was quite shocked 'cos I don't think he quite, I just came out and just blurted it all out and said, 'look I feel like I need a little bit of help here'. He was really good, he was really understanding as well, so the support was good and the services that were available were good.*

Accessibility

For the non-military spouses and their serving partners, healthcare provision on the whole is delivered by two different providers; for families, healthcare provision is civilian NHS primary care, and, for the serving partner, healthcare is delivered by DMS. This potentially created further areas of frustration for participants due to the lack of awareness from civilian services regarding the military spouse's experience and lack of accessibility to DMS services for the military spouse to support their serving partner. Military personnel are not registered with civilian General Practitioners (GP) and would only access NHS care for the provision of secondary care in hospitals. However, Vikki described that because Darren initially would not go to DMS and she was unable to access DMS to raise concerns about his mental health, she took him to her own GP out of frustration. While Darren was seen by a GP, they were told Darren could not use this service and were advised that Darren access DMS. Vikki explained:

> *I've even taken him to my own doctors before and they've seen him 'cos you know he wasn't right and I'm like 'this needs sorting' you know what I mean* (pause)? *No, they weren't supportive, no 'cos obviously I didn't go in the room with him and then he saw the practice manager and she was like 'well we shouldn't really be seeing him neh neh neh', and I was like, 'he's not well', and 'he will be coming to you when he's out anyway'.*

Whilst Vikki's story was initiated out of a lack of access to be able to support Darren fully, it was also illustrative of participants' feeling that they were not being heard by another avenue of formal support. Within the participants' stories, there were examples of inclusion and also a lack of inclusion with the service offered by DMS; these are explored in category 5: Diagnosis and treatment.

For the most part, it was the access to welfare services that featured within participants' stories. To access the welfare service, there is no requirement for the serving member to make the initial contact; thereby promoting equal accessibility to any serving or non-serving member of the military family. However, there could be incongruence between this policy and what was felt as happening in practice by the military spouse. Cathy argued that:

> *From a wife's perspective, I don't find them approachable, the whole system is not approachable 'cos you have to, I can't just rock up into camp, knock on welfare and say, 'there's an issue', you know I can't do that, it's usually the serving member that has to go in and say, 'there's an issue'.*

In addition, the initial promotion of the welfare service is routinely placed with the serving personnel to raise awareness within their family. Christina explained:

> *...as much as welfare is there, if they* [serving partner] *refuse to give it out, they are not very 'erm and that's not the army's fault, I would say that's more the fault of the individual soldier who doesn't point their wife in the right direction.*

Despite Christina, Lindy, and Sophie stating that they would have felt uncomfortable involving welfare, the importance of having support initiated by the military welfare team was highlighted by others. When serving personnel are wounded, sick or injured (WIS), they are entered onto a database for monitoring and support; the welfare team are involved in those reviews. As a result, the welfare team will know which military families may potentially need support. Sara explained that while she did receive support, she had to initiate it: *I felt like I had to seek them, they weren't provided.*

As well as sharing examples of their experiences with welfare services, participants also hinted about what they would have liked to have happen This was generated in response to one of the questions I asked in the second interview, 'Looking back at the whole experience, what would have helped you?' In response, participants talked about the importance of accessibility to services and different treatments or the lack of available services. Lindy's serving partner was an officer within the military; she felt that because of his role within the army, Craig was reluctant to access DMS provision:

> *I think there needs to be more services, definitely all kind of levels but definitely at officer level, there needs to more of an open thinking.*

Whereas Vikki simply wanted an avenue to seek support during one of her partner's acute episodes of mental illness:

> *In an ideal world, I would have loved to be able to ring a number so that someone could* [come] *here and take him away, that would have been the proper solution. If I could, when he was on one, say 'yeh just come and take him away until he calms down and bring him back when is normal'. Do you know what I mean?*

Because of the complex nature of military relationships, Simone and Cathy highlighted a need for a military service that provided couple's therapy. This was expressed by Simone:

> *I think if they did do sessions, just do couple sessions, they can talk about it, anything they've seen or anything they want to talk, 'cos obviously he never spoke about anything until like now. So, if he had been able to talk about that, actually being in a session to talk about it we might not be in this position now, 'cos it's a build-up of all this time.*

Family and friends

Just as participants talked about positive and negative experiences of formal support, participants shared both sides of their experiences of informal support. All participants except Sophie, alluded to family or friends as a mechanism of support. Whilst Sophie said that she was a very private person, her support unit being her husband and son, for others, wider family members were a positive source of support - for them and their serving partner. Vikki and Harry encapsulated participants' views:

> *I don't think I would have got through half of it, if it hadn't have been for my mum and dad 'cos I would just tip up at the door or ring them to say, 'I'm coming over with the kids' and they were like 'yep that's fine, not a problem', you know* (Vikki).

> *...my parents know, so they've been there, always offering wanting to come up and my mum took an extra day off a month to come up and she has done it a couple of times* (Harry).

However, not all family support was deemed positive; for Christina, it was ambivalent since judgements were voiced about her partner, Daniel, when she disclosed his behaviour with members of her family:

> *...if I ever, I ever opened up a little bit to family members, one of my aunties, who I'm really close to said to me 'that's not normal', she said 'you're not being any more than a normal woman, not asking anything outrageous, you're not, if anything you are actually more understanding' she said, 'that's not normal'.*

Cathy found that the physical distance away from her family was a barrier to support, leaving her feeling isolated:

> *My family at that point, I live in Dorset, they live in Sheffield, just it felt like they just never, they never rang, they never come to see us. I've then felt like isolated…. when it's just you, him and the kids, it's very intense. I think people at home take it for granted that they can, the silly little things, if they go away for the weekend or they wanna go somewhere, mum or nan or grandad or aunties and uncles will just have to help out.*

As well as family, friends were also mentioned as a mechanism of support for either participants or their serving partner. For Christina, Lindy, Simone and Sara, the support and friendship came from other military families, which as Wang et al. (2015) recognised, purporting that the military community can support resilience building. For Harry and Vikki, the friendships had no military connection. Christina, Simone and Sara specifically cited friends from other military families as their support. Christina and Simone explained:

> ...you *sort of surround yourself with people, don't you? I've always found that wherever I've gone I've always felt really lucky, I've like immersed myself in people that can get you through, distract you* (Christina).
>
> *...had a couple of friends from where I worked but they weren't military, I had my friend Caroline and Alex, they were military* (Simone).

Harry, Cathy and Sara also spoke about the support that their serving partners had received from their friends. Harry explained that Nicole had:

> *...still got a good circle of friends, two or three friends all the way back from school... her close friends know that it's PND* (Post-Natal Depression).

In contrast, Lindy who had been a military spouse for 30 years, explained that in the early years of her marriage, she felt that she did not want to connect with other military families and made a conscious effort to avoid military friendships. However, Lindy found having non-military friends equally problematic:

> *I didn't even want to get into it, so I spent a lot of my time getting into, trying to make friends in civvy street but that's really difficult 'cos people don't know what the life's like, they don't know what it's like to be around.*

In more recent years, Lindy had joined the military wives' choir and, although members shared the experience of being a military spouse and this commonality might be expected to lead to openness, sharing and support, Lindy explained that this was not necessarily the case:

> *I think even singing in the choir sometimes you get so moved…* (pause) *but I think even in that kind of group, I think there's a friendship there, but I still think we keep it in.*

Moreover, from those friends with whom Lindy did choose to share and seek support, she wondered whether, because of the longevity of the struggle she had experienced, they had grown tired of listening to her:

> *…some friends know kinda a bit of what is going on but they are sick of listening to me, they are sick, well I think they are sick of hearing me 'cos I say the same old thing and I kinda think* [they think] *'why don't I do something about it?' which would be to leave, but you either put up with it or you don't and I tried to tackle it when I tried to speak to him and sometimes he goes 'yeh yeh I get it, I get it' and then we are back to the same old thing* (pause).

This ultimately led to Lindy feeling that she had *really not had any support from anyone, I've not had anybody to turn to.*

Secondary mental health issues in spouses of those living alongside someone with a mental health issue have been well documented (Lambert et al., (2012). In a military spouse context, the majority of studies make specific reference to secondary PTSD as highlighted in chapter 2 (Lyon, 1999; Iniedu, 2010; Waddell et al., 2016). Despite the evidence base, the onus of identifying the need for help or indeed seeking help, falls on the individual. For military spouses, the identification of their own mental health issue was problematic since they were very often immersed in giving support to their partner with a mental health issue, managing and running the family home and for some, working outside the home. The extent of their own mental health issue, therefore, might not be apparent and overlooked. During Harry's interviews, he expressed feeling that he had coped well throughout Nicole's mental health illness; however, he considered and hypothesised who might have identified a secondary response, should he have been unable to cope:

> *...military wise, there is that weird disconnect with it all and I don't know if that's with, and I don't know what would have, I don't know how it would have been caught if we had both decided we were not coping. I think it would have been, obviously my work would have but yeh, I don't know.*

While Harry was able to hypothesise who might have noticed a decline in his own mental health, Lauren was less confident that it would have been noticed in her:

> *I think if I had gone funny [developed a mental health issue] and I'd gone a bit off the rails, I don't where that would have been caught* (long pause).

It becomes a thing!

Whilst support and/or a lack of support was identified, participants also highlighted the stigma around mental health which they perceived existed within some of the military. Participants felt that it was this continued stigma that presented a barrier to their serving partner or, indeed themselves, initiating support. Consequently, this led to some of the participants' serving partners denying their mental health issues and covering them up, at work and socially. All participants to some degree felt that their serving partners' mental health issue then became '*a thing*', (as Harry expressed it), either for themselves, their serving partner or both. Harry made a comparison of mental illness to physical injury, with physical injury being in his words, a 'proper' injury, and the lack of knowledge and consideration of mental health issues by Harry prior to Nicole's post-natal depression, reinforced the perceived stigma. The stigma towards mental health, he felt, was perpetuated by the military because of the processes and pathways of sharing and hierarchy in relation to Nicole's officer status:

> *I'm talking relatively recently but we have recently experienced it* [post-natal depression] *but, if you go back, it wasn't really talked about, really. I think we have friends that have got problems, that have proper injuries; I say proper, I mean physical types of injuries and things and then had to deal with those... I'd say from any officer, a lot of times, they don't want everybody knowing about it and, there's it going to welfare, the more people that find out it becomes a thing.*

Although Harry and Lindy related the denial and/or covering up of mental health issues as indicative of rank, with reference to officers' attitudes to mental illness, it was suggested by all participants that this behaviour was present regardless of rank. Christina summarised the point felt by all: *No-one in the army knew until now, he's totally got a game face on at work, no-one knows the problem.*

By using '*game face'* Christina was suggesting that Daniel maintained a strong determination to succeed in work; he did not let others see that, at times, he was struggling with his mental health because he did not want it to become 'a thing.' Cathy, too, recognised that not showing emotion was 'the army way'::

> *I think that is like a form of something from the army, I do think that they are, from such a young age are kind of, it's drilled into them not to show any form of emotion whatsoever and that went on for years.*

Maintaining a *'game face'* was not just evident in the serving partner, the same was reported by participants in their own interactions with family and/or friends; they said that they never really shared the full extent of their experiences and therefore it was possible that they never really received the support that they might have received, had they been truly open. Lauren captured this:

> *The only people that you have to vent to, is friends but you can't vent the real extent to them 'cos you don't want them to think that everything is rocky at home, 'cos you don't want them to think that, you want everything to seem ok, 'yeah it's not as good as what it was' you can say but you don't want to be 'oh my god, they're on the verge of divorce' like you know, that's a lot of it. It's the same with family, you don't want to tell them the true extent of it because otherwise, everyone's very judgy, aren't they?*

As alluded to earlier, participants described a prevailing military culture of stoicism; this did not just exist or stop with serving personnel but included the military families. There was a culture of stoicism whereby it was perceived that members of a military family, living alongside serving personnel should 'carry on', and endure any hardship without complaining. Living within the military culture, it would appear the stigma surrounding mental health issues was not only perpetuated within the confines of camp, but also wider within military families themselves.

Diagnosis and treatment

In order to explore the experiences of living alongside a serving partner with a mental health issue, part of the inclusion criteria for this study was that the serving partner had received treatment or therapy for a mental health issue. As mentioned earlier, diagnosis and treatment of the serving partners' mental health issue happened much later in the participant's journey. As seen in earlier categories, the participants noticed and tried to 'fix' their serving partner's mental health issue before seeking formal help. The stoicism in military culture (chapter 3) not only prevails within military personnel but also across military families (Gray, 2017), and often disruptive or deviant behaviours are hidden by the family (Harrison, 2006).

Diagnosis

By recognising the stigma which exists, the stoic military culture (chapter 3) provides some explanation to the delay in a formal diagnosis. In addition, there is an explicit requirement for the serving person to recognise the mental health issue in themselves and self-refer into services. As highlighted earlier, this is fraught with concern since many people experiencing a mental health issue do not recognise it (Mellotte et al, 2017); earlier identification is more often seen by those around them.

The diagnoses of the serving partner included anxiety, depression, post-natal depression, and adjustment disorder. Simone's serving partner was receiving assessment for PTSD at the time the interviews took place; however, this assessment was undertaken after he was medically discharged from the army. Interestingly, not many of the participants spoke about the actual point when the diagnosis was made and, when it was mentioned, it was a fleeting sentence in their stories. Sophie and Simone simply stated:

> *The doctor finally decided to sign him off with the depression* (Sophie).
>
> *The doctor told him he had depression* (Simone).

Lauren and Harry went into a little more detail. They explained:

> *...when he first was diagnosed with depression, so he got quite a high scoring on his chart, the only thing that he didn't score on was the self-harming and the suicide.* (Lauren)
>
> *...it has been post-natal depression from Sophie but, it was sort of the build up to, so going back, she had it before 9 months.* (Harry).

Possible explanations for the lack of emphasis surrounding the diagnosis in participants' stories, may be because they had already been living with the mental health issue for so long prior to the diagnosis that, at that point, it was insignificant in their experience. Also, because there is no joint access to DMS, and most serving partners attended appointments on their own, the lack of inclusion from the appointment, the lack of sharing about the detail within the appointment and the lack of emphasis about spousal support from the clinical practitioners, could go some way to understanding why there was little disclosure about the diagnosis.

Treatment

Treatment plans vary depending on the mental health issue and the severity of the symptoms and should be individualised dependant on the exact circumstances surrounding the individual (NICE, 2011). For common mental health issues such as depression, anxiety and post-natal depression, treatments include medication alongside psychological therapies such as talking therapies and, counselling

(NICE, 2011). The most common treatments received by the serving partners with a mental health issue as described by participants were medication, counselling or both. This category draws upon the participants' stories when they specifically spoke about the treatment episode and includes three subcategories: engagement, inclusion and secondary response.

Engagement

All serving partners of the participants except Craig (Lindy's serving partner) had received treatment from the DMS. Craig self-referred to independent counselling and couple therapy from which Lindy had felt he disengaged:

> *Couples therapy... he's just lying again and if he did it to me, that's the biggest sin but then if you did it in therapy then your kinda not using it really* (pause) *and he has started doing to the therapist what he has done to me really, cancelling sessions because he would have work and he would do it at the last minute. At first, she did accommodate him and kinda did what I did and made excuses for him and then after a while, she stopped doing that.*

Following initial assessment and subsequent denial of treatment from the DMS, Cathy's serving partner Adrian's issues surrounding premature ejaculation were viewed as marital issues; however, it emerged that this was a physical response to anxiety caused by the stress of the army lifestyle. Evidence suggests that over a third of young (under 40 years) military personnel state experiencing some level of sexual functioning problems or erectile dysfunction (Wilcox et al., 2015; Clifford and McCauley, 2019). Adrian self-referred to an independent specialist individual and couple counsellor. During the individual counselling, Cathy reported that Adrian had:

> *...found out through the counselling, that actually* [the premature ejaculation] *was something that the army had, well their lifestyle had caused him* [the anxiety], *because everything is always timed everything is always quick, everything has got to be done, everything has got to be done, you know like I said, 'be ready then just wait'.*

Christina also identified the army lifestyle and how she felt that it had exacerbated Daniel's anxiety:

> *I think he has been this person, since before he joined up and I think the army life has exacerbated the person he is, the hurry up and wait, the high intensity of the situations.*

In addition to the treatment received from DMS, Cathy and Simone's partners chose to seek external therapy. James (Simone's serving partner) independently sought additional therapy through complimentary hypnotherapy treatment. Addrian (Cathy's serving partner) sought independent specialist therapy. Both avenues were successful from the participants' perspective; Cathy explained:

> *This woman is amazing, this woman saved our marriage, don't know how she has done it, but she has 'cos I'd literally had, I was just waiting really until, I had asked him to get help, he didn't and now he has, we are better than we have ever was in thirteen years ago, so yeh it's a happy ending, 'erm and he is a completely different man.*

For all who attended the DMS, the first line treatment was counselling, followed by a drug treatment - if there had been no improvement following the counselling. Initial positive responses from the counselling were observed. From Vikki and Sophie's perspective, the counselling was enough; Vikki said:

> *A lot of the time, the people that he saw down at DMS, would come back and give him different ways of looking at things.*

Harry and Sara explained how their serving partners - Nicole and Tom respectively – ultimately, had engaged with all stages of their treatment package. The package included both talking therapies and drug treatment which, they felt, led to positive outcomes. Sara acknowledged, however, the longevity of Daniel's treatment journey, and that talking therapies were offered separately and at differing times to the drug treatment. Rather than having the two treatments in tandem, Sarah felt that the counselling alone was only effective during the treatment period and not once the treatment had ceased:

> *He went to counselling 'erm and that did help while he attended counselling it was great, the minute the counselling stopped his mood would dip again. And the only thing that seems to have controlled it is he started tablets this time last year, Citalopram, and that's helped, he's like a changed man but it's taken a year for it work and he hasn't had any more bouts, so far so good.*

Sara's experience was reflected in Christina's serving partner Daniel's journey:

> *He had a few counselling sessions which I think went over the six-month period and attended those 'erm and then that sort of fizzled out and he didn't have any more following, he was offered medication.*

In contrast, it was observed by some of the participants, including Christina, that their serving partner did not always take prescribed drug treatment and, subsequently, experienced relapse and recurrences of their mental health issues:

> *He was offered medication, which he took home but didn't take, he declined and then so that was 2015 and then this time last year so yeh 2017 last year, he had chest pains, got to the point where I was like 'you need to go seek help for that' I says, 'you need to go back and do counselling again'.*

In addition to talking about the support on offer for their serving partner, some participants reported seeking a form of support and/or treatment from formal services themselves. The commonality in the accounts was the timing of the felt need; very often it was when their serving partner was also struggling. Sophie typified this by explaining:

> *…he was in the grips of depression, and I was in the grips of depression, and it was a really bad atmosphere……for me I would say 'I'm better', I refused any kind of tablets, I didn't want tablets, I did do some talking therapy like just phone conversations.*

Inclusion

As explained earlier in chapter 1, throughout the NHS it is widely recommended that the inclusion of families in the treatment of clients with a mental health issue can aid recovery and provide vital support in managing the condition for clients and families. Such provision is documented in NICE guidelines (2005, 2011, 2014, 2015, 2021), providing written and verbal information regarding the diagnosis, treatment, and recovery, specific to the mental health issue, along with advice for families on getting help in a crisis. For most military personnel, (including most in this study) treatment is delivered in-house by the DMS and, ordinarily, there is little or no access provision for military spouses.

The findings of this study suggest that there was very little or no involvement of the military spouse in the treatment of their serving partner. Lauren and Vikki described attending appointments with their serving partner in order to ensure that their partners told the DMS everything, as Vikki summarised:

> *I went with him to the doctor's a couple of times just to, he did ask me along, he said 'do you want to come with me?' So, I said 'yes' because I wanted to make sure that he was telling them what was going on and he was.*

Lauren also felt that her involvement would help her to learn about the issues and how to manage them:

> *I think it's like working together as a doctor, mental health nurse, him and me altogether in it together 'cos otherwise I'm none of the wiser. I just know he's going for these appointments and all I get from him is 'yeh they're alright, they're pointless' and that's all I get* (nervous laugh) *...that's all he said to me, and I don't know what they discuss in these meetings, like they could discuss anything. I don't want to know everything, but if he's got somethings that he wants to keep private, then that's fine, and I'm his wife, I'm not his mum. Like I'm not gonna babysit him but yeh it's I just think it's getting the understanding of it.*

When the General Practitioner (GP) at the DMS was involved, Vikki felt that she was not necessarily asked for any input but at least she acknowledged her:

> *A Dr Simpson or something like that, and she was like 'right this, this, this and this'* (talks sternly)*. It was very sort of blunt, but it was what he needed. She said, 'if you are feeling like you are losing control', she said 'you get up, you remove yourself from the situation and go and have 10 minutes in the garden, go and sit in the car, go for a walk around the block. You're in control, you sort yourself out' and it was very you know, I could have hugged her, do you know what I mean?*

In stark contrast to their positive experiences of the DMS GP's, Vikki and Lauren found that they were not included when the DMS specialist mental health team were responsible for delivering the treatment or care. This was mirrored in other participants' experiences. For example, despite feeling an element of respite when the help and support had shifted from informal support to formal support, Christina still felt that her inclusion by the specialist mental health team would have been beneficial:

> *Looking back on that, I think it would have been so much better if the military had involved us a little bit 'cos like Daniel didn't talk about it, I didn't know*

> *what was happening, it was almost as if like I wasn't needed, which was strange, it's a strange feeling which, which I was happy with, a bit of a relief, but then you just think, 'God it could have'…..*

Harry was surprised at this lack of inclusion, especially as the treatment had spanned over a lengthy period:

> *I would have gone for a chat with the counsellor 'cos I mean that was the best part of a year, every couple of weeks like that, but no, I was quite surprised there was no kind of,* [not] *even one chat…I was surprised, I was surprised. I think I said to her at one point, and I was very surprised that I've had no formal involvement at all, absolutely nothing…The connection to the military wise, there's been nothing really…*

Despite the lack of inclusion, participants felt they should be involved with the treatment. Consolidating all that was articulated by other participants, Harry said:

> *You know, it doesn't make sense to have somebody going through something like that almost. I suppose really, they are believing what that person is saying about what's going at home because they haven't had a conversation with the other person and some people just can't and are struggling to hide things. I suppose there is that there is that disjointed bit there, which doesn't make sense.*

Christina felt that inclusion in the treatment sessions would have helped her to know what was happening:

> *I think, looking back on that, I think it would have been so much better if the military had involved us a little bit 'cos like, Daniel didn't talk about it, I didn't know what was happening.*

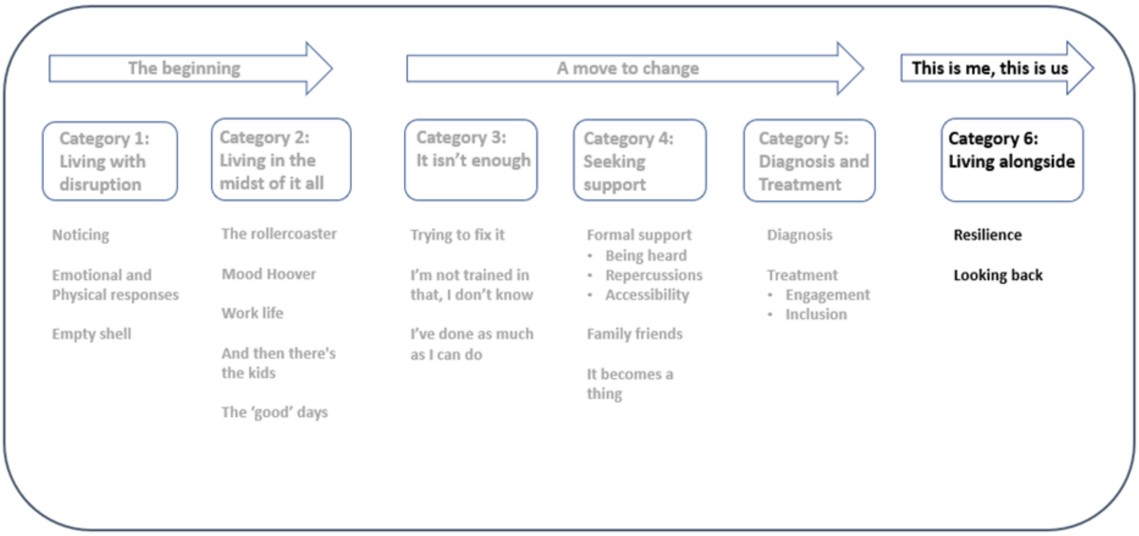
Lauren saw inclusion as an opportunity to learn and gain insight into how to manage the situation at home:

> *[I] think if somebody is, is going through depression, it's very important to, they automatically gets the partner involved 'cos what if say the worst case scenario and he was that depressed and although he has not declared he's thinking of suicide or declared that he wants to self-harm, how do I know what to look out for if he's going to kill himself if that's like? I don't know, you know what to look out for, you know.*

6.4 This is me; this is us

The third and final part of the journey portrays the participants' reflections of living alongside their serving partner's mental health issue and how they continued 'living for today'. Rather than concentrating on a specific time, this category focuses on the experience; reflecting on participants' resilience and the strategies they employed to live alongside their serving partner and maintain their marriage. The findings are presented under one category: living alongside. Figure 15 illustrates the category and subcategories for the final part of the journey: This is me; this is us.

Figure 15: This is me; this is us



Living alongside

It is recognised that living alongside someone with a mental health issue can be extremely stressful and emotionally draining (Action for Carers, 2022; Turner, 2020). As highlighted earlier, the trajectory of the mental health issues identified in this study fluctuated between remission, where the serving partner was mentally well, to periods of relapse and subsequent recurrence where symptoms were present. Within the participants' stories, there was recognition that the mental health issue was in some form always there; however, there was not one strategy for living alongside it. Protective factors varied; for some, it was about accommodating their partner's behaviours; for others, it was about the adaptation of themselves. In the extracts that follow, the differences between accommodating and adapting are illustrated. The periods of relapse and recurrence were managed to a certain degree by the behaviours of the participants living alongside their partner with the mental health issue. Christina and Lauren felt that they had become attuned to their serving partners and were able to sense a change. Lauren summed this up:

> *I can tell when he's had a really bad day…. I can sense it and I don't like it.*

This final category is made up of two subcategories: resilience and looking back.

Resilience

Through the experiences over time, the majority of participants recognised in themselves, various protective interpersonal strategies of adjustment. These were through avoidance and accommodation when responses or behaviours were present. Intrapersonal strategies by adapting within the marriage in order to '*survive*' and cope with the day-to-day experience of living alongside their serving partner were also recognised. Over time, these strategies enabled them to adapt to their serving partner's mental health issues and cope with/manage their displayed behaviours. With each recurrence or difficult episode, participants appeared to be able to strengthen themselves. The notion of adjusting in order to protect oneself, as well as the marital relationship, was recognised by many; Cathy exemplified this:

> *You have to completely change your relationship anyway and you just have to either adapt or walk away…. he is not the person I met, he's a lot different to who I originally, see 'cos when I first met him, he'd never done a tour, but I was never gonna walk away because of my kids.*

Lindy's thoughts were similar, but went further, recognising that the adjustment to Craig's behaviours over the years were made by her and that her adaptations were fluid and required constant modification to protect herself:

> *I suppose in order to survive it, I have had to adjust quickly all of the time and I have become quite good at that... You have to have certain mentality 'cos I think most people would just go.*

Following a shift in her own behaviour towards her serving partner, Christina too, recognised that the changes made to protect the relationship were indeed changes to herself:

> *I don’t think Daniel’s changed at all since his initial treatment, I think I’ve changed, I think I’ve changed how I interact with him.*

Participants gave examples of how they adjusted in response to the different moods and behaviours of their partners. Cathy and Sara explained how they avoided confrontation wherever possible and used avoidance as a strategy for survival. They would physically remove themselves - or others - from the situation and, withhold information that they saw as potentially triggering their serving partner’s negative behaviours. Sara elucidated this by describing how she tried to:

> *...anticipate his* [spouse’s] *reactions to certain things or maybe or ‘erm, disclosing like withholding maybe certain information to not maybe upset him as much………We* [Sara and her son Jack] *just avoid any confrontation really ‘cos we are not really one for confrontation…… So, if Jack is having a bit of a bad day, we wouldn’t tell him* [spouse] *‘cos it might trigger him a little bit and he’s on edge or I’ll let him have a lie in* (laughs) *just to try and keep Jack away from him for a little bit and just things like that. I am very mindful when he is not having a good day.*

At the time of the interview, Jack was six years old. Jack’s bad days referred to days or periods of time when Jack was unwell, over excited or over tired which caused him to be whiney or behave mischievously. Not only did Sara have to look after her son, but she had to be mindful of the effect of her son’s behaviour on her spouse. Christina, in contrast, accommodated her partner’s behaviours, rather than avoiding him. Christina accepted her partner’s outbursts of anger, intervened and made attempts to pacify Daniel into calming down:

> *Like the bursts of anger come out of nowhere and I’m just like ‘oh my god, like what the hell?’ I was at a point where that was normal and where I would do everything I could to keep him calm and to, I don’t know if I made the situations worse, but I like just used to go quiet, let him get his anger out and then do his bidding, whatever, just to make him happy.*

As more time passed, however, Christina described changing her strategy to try to defuse the situation; she moved from accommodating the outburst and trying to calm the situation to challenging Daniel and his behaviour. Christiana shared one episode where she had challenged the outburst:

> *I said, ‘well see ‘cos I didn’t pander to your temper there, you had to think about your actions, and you had to rationalise them and not lose your*

> *temper.' I said 'if I had like, if I had have blew at you or if I had have catered to you, you could have kept going and going but I made you stop and think about your actions' …*

On challenging the behaviour, Christina recognised her growth in resilience; she had 'toughened up' in her response to those difficult episodes:

> *I'm definitely proud of myself. I thought 'brilliant, so I had defused it a bit' and then I, and he said something like 'eey I can't believe you did that, it's not like you' and I said 'well I wasn't putting up with your temper' …I would have never would have done that ever, well I don't know if I've toughened up. He was just laughing, so yeh, we've come through something.*

In contrast, after years of constant adjusting to accommodate Craig's mental health issue and subsequent behaviours, Lindy's resilience to protect herself and the relationship had diminished. For Lindy, it had always felt like a fight to keep things going and she had reached the point of exhaustion. She felt that she had always accommodated Craig's behaviours:

> *I guess I have always done everything for him, and I have accommodated him, and I suppose I am quite good at that.*

Withdrawing all of her actions to accommodate Craig and protect the relationship, however, led to a new level of self-awareness. Lindy started to recognise how much she had sacrificed:

> *But in not filling the gaps, I just kind noticed how much I have given up and put up with not doing but it has kinda helped with the anger 'cos I am sort of saying 'well I'm not gonna fight it anymore.'*

Looking back

This study *by its nature,* was all about looking back at the participants' experiences of living alongside their serving partner with a mental health issue. Specifically, I asked participants in the second interview, '*Looking back, what was it like for you?'.* As discussed in chapter 5, when I asked participants to tell their stories in the first interview, all proceeded to tell a conjoined story about themselves and their serving partner; the participants themselves were not always easy to locate in their stories. The second interview provided the opportunity for participants to share something about themselves; to focus on their own thoughts, feelings and experiences.

Looking back on their journey of living alongside their serving partner with a mental health issue, conjured up an array of feelings and emotions. Lauren and Harry summarised the whole experience:

> *I mean I am quite a strong person but that really challenged me like (Lauren).*
>
> *I think the whole, the whole period is really odd... it's just amazing how quickly you kind of sort of blank out the day-to-day stuff (Harry).*

Unsurprisingly, participants identified some of the emotions that were reminiscent of an earlier category, 'living in the midst of it all'; namely, anger, resentment and loneliness. When looking back, there was a general feeling of 'heartache', Cathy summed this up:

> *I lived my whole life miserable so really, it's been seven years of all that heartache and pain wouldn't have been there.*

As identified in the inclusion subcategory 'diagnosis and treatment', their lack of inclusion and invisibility was expressed by participants; the feeling of invisibility and a lack of recognition from their serving partner was also expressed by Christina and Lindy. From within the marital relationship, Lindy felt that she had always *been fighting for attention.*

Lindy's inference of the lack of attention from Craig was a direct result of his mental health issue, whereas Christina attributed her invisibility to be a direct result of Daniel's job; for Daniel, she felt, the military came first and foremost:

> *Daniels always been my number one and I'm always giving me 100% but he's never gave that back 'cos he's job, I've always accepted that, I've always have, always will. I'm never first but I get that 'cos its fine, it's not his choice but even when I could be his first, I never really am and it's hard to have that it's almost like an unconditional/non-conditional relationship*.

The feelings of invisibility were in some ways unsurprising because participants had alluded to this earlier in their interviews, but here, in answer to the specific question about how it was for them, it appeared that participants were invisible to themselves in that they had lost their sense of self/individuality; they were primarily a wife, and a military wife (seed discussion in chapter 3). The first interview, when asked '*tell me **your** story?* was consumed by the alternative story of their serving partner and their mental health issue.

Lindy did acknowledge some recognition of the role a military spouse plays, albeit not from her serving partner or indeed the military but from a gesture by the Queen:

> *We went to Windsor Castle once and the Queen allows wives and dependants in for free because she recognises the importance of family, that's the only time I have ever been recognised and I was nearly in tears as there is no recognition or no thanks [*from partner or military].

Just as described under the category '*noticing'*, whereby participants highlighted the emotional detachment of their serving partner, when summarising their experience, Lindy and Cathy recognised their own emotional detachment; Lindy encapsulated this feeling:

> *I would say I am with this empty shell, and I have become more of an empty shell because of it.*

Despite this emotional detachment, Christina and Lindy continued to remain invested in their relationship but for conflicting reasons. Lindy saw the sacrifices that she had made such as accommodating her spouse's difficult behaviours and felt that she deserved a reward, something in return:

> *I think I've kinda, there's a part of me that's put so much into this lifestyle that I never ever wanted that I feel I want something back.*

Whereas Cathy and Christina recognised the gains:

> *I thought this is so sad that for all these years our marriage has been tainted with this issue and actually it's only now that we are the happiest, we have ever been* (Cathy).
>
> *…. you sacrifice a lot but then you gain a lot* (Christina).

For Christina, these gains were social:

> *You gain a lot, the people I've met the network of the people I've got across the country is unreal, I'm really, really like I would never change that.*

But also, from a marital relationship perspective; whilst Christina recognised the continued existence of Daniel's mental health issue, she felt that her experiences had in some way strengthened the marriage and, moving forward, did not seem as daunting:

> *I just think the whole, I think it's just a circle, and I don't think he's out of it, I don't think he ever will be, it's something that's gonna carry him through life,*

> *and I'm always gonna be frustrated being supportive. But we're probably the strongest we ever have been…. we can conquer anything.*

6.5 Summary of categories

The beginning makes explicit the initial periods when the participants realised, felt or observed, prolonged changes in their serving partners' behaviour that were disruptive to either their partner, their own selves or the relationship. The unpredictability of living alongside a serving partner with a mental health issue was apparent and likened to riding a '*rollercoaster'.* Likewise, the strain of uncertainty and the unpredictability of the serving partner's mood and the impact felt on the participant as a result is demonstrated. Previous military literature has highlighted the impact on work and children; however, unlike these findings, the research is predominantly focused on the effects of deployment on children. From a work perspective, previous research predominantly has focused on the veteran population rather than serving personnel. It is evident that the beginning of the journey shares some parallels with existing literature pertaining to the physical and emotional responses and withdrawal; however, specific reference to spouses observing initial behaviour changes in serving partners is not explicit in previous studies. This is explored in more detail in the discussion chapter (chapter 7).

The findings from a move to change, illustrate the progressive journey made by both the participant and their serving partner. An explicit, inherent felt need for participants to '*fix'* their serving partner with a mental health issue was apparent. Some took a maternalistic approach, whereas others were much more practical but what was central to the participants' need to help was the recognition that they needed the knowledge to do so. After a period of trying to '*fix*' their serving partners' mental health issue, participants had reached a point where they no longer could cope, their marriage was threatened and, in some cases, had started to deteriorate. These threats led to ultimatums within the relationship and subsequently, access to support.

Few participants mentioned the point of the serving partner's diagnosis within their stories and, when they did, it was done briefly. There was more focus on the treatments received. For most serving partners, treatment involved medication, talking therapies or both. The participants spoke of their serving partners' engagement with treatment and also about their inclusion in those episodes. The mechanisms of help and support fell into two distinct types. For the serving partner, most help and support came from formal services through DMS; whereas for the participants, despite the availability of formal support via the military welfare service, many sought and/or received support from family and friends. However, participants felt that the support was not always given without offering judgement. In addition to the support, stigma within the stoic military culture (chapter 3) prevailed and, as such, became a barrier for all.

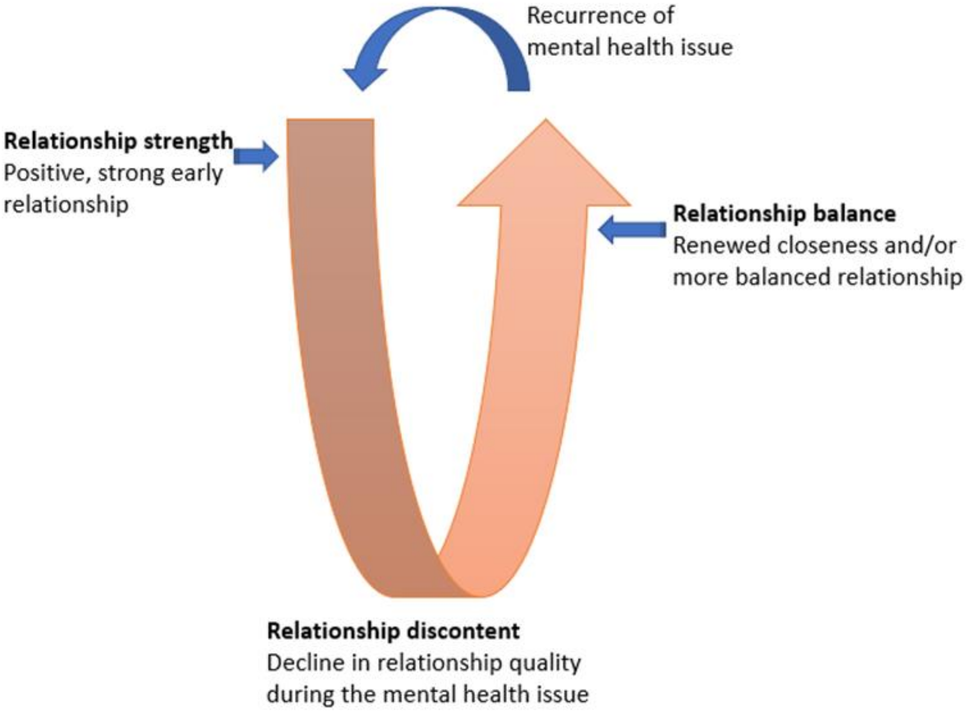
The journey moves then to explore *'this is me, this is us'*. Whilst it appears to be the final part of the journey, the arrow in the illustration signifies the journey is to be continued. This part simply captures the changes in them and their reflections to date and by no means signifies the end of the journey. Indeed, what is recognised is ongoing feelings where for some the heartache continues and for others a brighter future is acknowledged.

6.6 Overarching summary – the convergence

Underpinning my initial thoughts in chapter 3, my conceptual thinking, specifically relating to military culture allowed me to explore the wider cultural elements which inform many military families. Likewise, using Lieblich et al.'s (1998) framework for data analysis, facilitated interrogation of the data in two different ways: holistic-content and form, plus category-content. Taking a holistic stance allowed me to illustrate the whole stories in context for each participant as individuals. It illustrates the context of each participants early relationship status and a demonstration of how the participant was situated in their relationship with their serving partner. As a result, this provided an understanding of the relationship prior any disruption. Interrogating the data using the category-content dimension of the framework, permitted the deconstruction of the stories to generate collective sub-categories and categories from across and within all the participants' experiences.

Reflected in the previous literature/research and generated from the data, it was evident that there was also a dynamic element regarding the perceptions of the military spouses' experiences of living alongside their serving partners with a mental health issue and that this warranted further analysis. I made the decision not only to interrogate the data separately to produce two in-depth interpretations, but to converge the theoretical underpinnings of my conceptual thinking and the two findings for further analysis and conceptualisation. The convergence of the theory relating to military culture and the findings led to the development of an overarching conceptual model illustrating the relationship trajectory during one episode of a mental health issue. Whilst the individual journeys were varied, the majority followed the same trajectory, and there was evidence of the previously discussed military culture interwoven. The trajectory resembled a U-curve. A positive, early relationship status is described in the beginning. This was evident in relation to military marriage; - how it is reinforced within the military organisation as being married continues to be incentivised and viewed as the norm (McCone and O'Donnell, 2006). It is widely recognised that relationship disruption within the military is not uncommon, occurs more frequently than that of civilian counterparts and is recognised as a result of the work demands placed on the serving partner, such as long hours and deployment. Indeed, the disruption and its impact has been recognised and theorised specifically within the emotional deployment cycle ((Esposito-Smythers et al., 2011; Lowe et al., 2012; Hawkins et al., 2018; Long, 2021). The disruption and uncertainty of living with their serving partners' mental health issue highlights similar findings. It leads to a decline in relationship quality and an overall downward trajectory for the relationship during this time. Initial management of symptomology and the change in behaviours were kept internal to the family unit. This is indicative of the stoic resilient enculturation (Harrison and Laliberte, 1993; Enloe, 2000; Gray, 2017; Cree, 2020) and the continued existence of mental health stigma (Acosta et al., 2014) for not only the serving partner, but also the military family unit within the organisation's culture However, in this study the pressure to uphold the military expectation declined with the continued disruption and uncertainty caused by the mental health issue, this led to action by both the participant and their serving partner. Seeking, accessing and engaging in external support and specific therapies steered the relationship journey on an upward trajectory to a renewed closeness and/or more balanced relationship. And thus, supporting the previously theorised nature of military marriage (see figure 16). Due to the nature of mental health issues and the possibility of recurrence, I found that within the stories where recurrent episodes of metal health issues were highlighted, the same U-curve trajectory prevailed. To that end, a noteworthy observation was that relationship balance may be achieved during times of remission or when there is concordance with treatment and therapy; however, during recurrence of the mental health issue, the U-curve journey may be repeated. Indeed, Christina and Lauren likened it to being on a circular trajectory.

Figure 16: The U-curve journey



6.7 Chapter conclusion

Presented in this chapter are the findings from the category-content analysis. To end this chapter an interpretation of the overall journey trajectory following the convergence of the two different findings (chapter 5 & 6) is discussed. Verbatim quotes have been used to illustrate the experiences of the participants living alongside their serving partner with a mental health issue. The conceptual journey is exemplified through six main categories and 21 subcategories, all of which are discussed. I have touched on policy, theoretical and empirical literature to illuminate and provide context. In the following discussion chapter (chapter 7), synthesis of the findings from both chapter 5 and 6, along with existing policy, theoretical and empirical literature provides a deeper understanding of military spouses' experience of living alongside their serving partner with a mental health issue.

7 Chapter 7. Discussion

7.1 Introduction to chapter

The previous chapters described and illustrated findings from data analysis from each of the two interviews undertaken with the nine participants. The final chapter of this thesis draws together the study's main findings, abstracting the findings from the participants' perspectives to explore and better understand their experiences within the wider context of previous research and theory. In doing so, it presents the thesis' original contributions to knowledge. The study's overarching strengths and limitations are presented, and implications for future research, policy and practice are discussed. The chapter culminates by presenting the thesis' main conclusions.

The focus of this study was to explore the experiences of military spouse living alongside their UK serving partner during a mental health issue.

To achieve this aim, the research objectives were refined to:

- investigating, through a biographical approach, the experiences of the military spouse whose UK serving military partner had sought support or treatment from mental health healthcare provision.

- explore the experiences of the military spouse during their UK military partners' mental health issue and to better understand their role in this process and its effect on the relationship.

- explore their experiences to develop a deeper understanding of the challenges and enablers which help military spouses in their relationship with their UK serving military partner during a mental health issue.

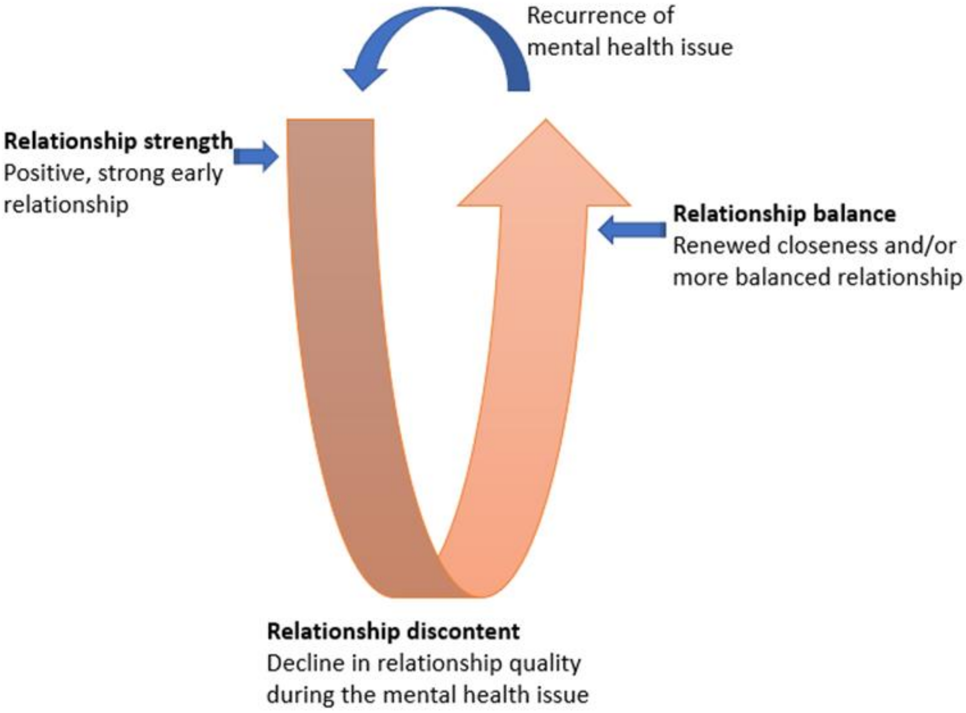
- use the participant experience to develop a deeper understanding and make recommendations for future research and for practice, in supporting military spouses and the care of serving personnel with a mental health issue.

7.2 Summary of study's findings

The aim of this study was to explore the experiences of military spouses living alongside their serving partner's mental health issue. Two differing analyses were applied to the data; this facilitated the rich contextual content underpinning each participant's story to be illustrated, as well as generating categories through the deconstruction of the stories, allowing differences and similarities between participants to be revealed. Through the convergence of the two analyses, a predominant trajectory of the participant journey was identified. The U-curve journey discussed in chapter 6 (illustrated in figure 16 &17) is used here as an overarching structure to discuss the findings. As highlighted in the previous chapter, due to the nature of mental health issues and the possibility of recurrence, it was noted that where the stories included recurrent episodes of metal health issues, the same U-curve trajectory prevailed. Therefore, a noteworthy observation was that the relationship balance was achieved during times of remission or when there was concordance with treatment and therapy; however, during recurrence of the mental health issue, the U-curve journey may be repeated.

As stated above, this discussion draws together the study's main findings, abstracting the findings from the participants' perspectives to explore and better understand their experiences within the wider context of previous research and theory presented throughout the thesis. Where, in particular, I touch upon policy, theoretical and empirical literature not already included in the thesis, I provide context and rationale within the discussion.

Figure 17: The U-curve journey



Relationship strength

To address the aim of the study, a biographical approach was used. This allowed the participants to share their experiences from a point in their story chosen by them. All the participants began sharing their stories from the time that they had met their serving partners (chapter 5). This was unexpected since all were aware of the study's focus, and I naively assumed that they would automatically start at the point of their partner's diagnosis. However, it seemed important to the participants to share stories about the beginning of their relationship, either to give context or to illustrate the strength in the relationship and what they had experienced prior to the emergence of their serving partner's mental health issue. Whilst the study was open to individuals who could have been co-habiting partners, boyfriends or girlfriends, in the event, all who participated were married, and this was given importance in their stories. Although it was not my intention to specifically explore marriage per se, the commonality of the marital situation amongst the participants could not be overlooked. All the participants were married early in the relationship, these finding support those of Binnie (2017) and McCone and O'Donnell (2006) who purport a higher rate of marriage with the notion that military life fosters incentives for military personnel to marry. For some of the participants marriage entitled them to SFA which enabled them to travel and be located together with their serving partner. As discussed in chapter 3, very often, military families are displaced from their extended family; geographically - a result of postings - or emotionally because of the civilian family's lack of understanding about military life. What was evident in my findings (specifically, see Christina, Lindy, Lauren and Cathy's stories; chapter 5) was that the distance from family that was experienced, motivated relationship engagement and strengthened the bond between the military couple.

Traveling on a downwards trajectory

Unlike the majority of the military spouse literature (for example, Cuijpers and Stam, 2000; Arzi et al., 2000; Calhoun et al., 2000; Dekel et al., 2005b; Manguno-Mire et al., 2007), where the notion of being a carer and the subsequent caregiver burden is emphasised, no participant in my study made or implied that they were a caregiver. The emphasis throughout their stories was very much focused on the marital relationship. Other studies - such as Johnstone and Cogan's (2021) UK study of veteran spouses and Allen et al.'s (2010) US study of serving personnel and their spouses - also recognised the dominance of the relationship/marriage over the notion of being a carer (I discuss this further later on page 221). So, whilst my findings are not unique in this respect, it is important to acknowledge that the use of a biographical approach allowed for the identification of this distinction specifically amongst spouses of UK serving personnel. Many of the previous military spouse studies pre-empt or indeed lead the findings, through the use of assumptions in the aims of the study or the questions asked (Mansfield et al., 2014, Thandi et al., 2016; Murphy et al., 2018; Brickell et al., 2020; Johnstone and Cogan, 2021). Examples such as using '*informal care'* in the aim or asking questions about how life was affected by mental health illness, how the military impacted intimate and family relationships; or, in the data collection tools used, such as the relationship problem scale, fear of intimacy scale, and burden inventory (Riggs et al., 1998; Jordan et al., 1992; Manguno-Mire et al., 2007; Renshaw & Caska, 2012).The themes arising from the marital theories discussed in chapter 3 provided a useful lens through which to consider marital life in the military.

Whilst acknowledging the impact of deployment and indeed the application of the emotional cycle of deployment as a way of understanding the family unit during the post deployment period, there are other areas of military life that can cause disruption to the family. The constant need to maintain operational effectiveness such as logistical issues, fitness levels, pressures associated with rank and the pressure not to fail felt by serving personnel, can cause increased stress levels, as was highlighted in my findings (see, for example, Sophie, Simone, Cathy, Vikki, chapters 5 & 6). Such work demands and increased stress levels are indicative of '*non-deployment stress'* (Brooks and Greenberg, 2017). Their definition is based on the Health and Safety Executive's (HSE, 2007) definition of workplace stress which suggests that workplace stress can be attributed to six primary sources; demands, support, control, role, change and relationships. The armed forces exemption from the Working Time Regulations (1998) means that they use an institutional model that has a 24/7 availability requirement for serving personnel and can leave military spouses/families feeling second to their serving partner's career (Moelker et al., 2015). Current literature (Brooks and Greenberg, 2017) and seen within my findings, echo these feelings. Equally, there can be external factors outside of the MOD which can cause stress, such as illness, as illustrated by Harry's story where his serving partner (Nicole) was diagnosed with post-natal depression (PND). Although seemingly unrelated to her role within the MOD, it is worth noting that Appollonio and Fingerhut (2008) identified that women serving in the military are at an increased risk of PND. Undeniably, any one of these scenarios can impact and disrupt the equilibrium of the relationship as seen for participants in my study. Despite the underpinning cause of the serving partners' mental health issue, similarities in relationship disruption and discontent were noted across all the participants, with some topical similarities to the existing literature; namely, the emotional and physical responses of the serving partner (Thandi et al., 2016), emotional disconnect (Renshaw and Caska, 2012; Waddell et al., 2020; Brickell.et al., 2021), work life (Iniedu, 2010; Temple et al., 2017; Johnstone and Cogan, 2021), children (Brown, 2015; Temple et al., 2017) and disruptions caused by the serving partners' fluctuating moods (Thandi et al.,2016; Temple et al., 2017). While my study's findings mirror other studies, they provide further examples from individual lives and support the only other military spouse of UK serving personnel study findings pertaining to mental health (Thandi et al. 2016).

Relationship discontent

In my findings, the category 'living with disruption' highlighted the period when participants realised, felt or observed, prolonged changes in the response of their serving partner that were disruptive to either themselves or the relationship; ultimately, resulting in relationship discontent. As highlighted earlier (chapter 3), post-deployment and re-unification can be likened to a honeymoon period with new routines, or an experience which is associated with unique emotional stressors (Esposito-Smythers et al., 2011; Lowe et al., 2012). On return from deployment, reintegration into the family home poses challenges and stressors for all family members (Compton & Hosier, 2011; Lowe et al., 2012). Pincus et al. (2001) identified numerous stressors associated with post deployment and re-unification, some of which can impact directly on the marital relationship; these include: prolonged separations producing feelings of abandonment, the resurfacing of old problems, development of adjustment related difficulties and worry about the physical/emotional health of the serving partner. In support of this, Long's recent study (2021) found that the imagined impact of PTSD on the family was described more frequently than the imagined challenges of their serving partner returning home. As a result of deployment, inevitably, all family members change; whilst a new normal is sought, the effects of deployment can lead serving partners to express '*echoes of combat'* (Lapp et al., 2010). Long (2021) described this as families continuing to live with their serving partner's deployment (as if he/she was still there, experiencing combat situations) within the home environment. Within my study, military spouses explained how they would observe and interpret behaviours according to their understanding of the serving partner's deployment past; they worried that dormant mental health issues could surface after their return. Whilst a consistent finding across participants' stories, there is an argument that '*looking for signs'* manifests because formal support services specifically highlight them within post-deployment briefings with families.

Whilst there are parallels to existing literature about deployment and returning home from deployment, the detail of the initial behaviour changes is not captured in previous studies specific to military spouses' experiences of living with serving partners or veterans with a mental health issue; the majority of the detail is post diagnosis and the felt impact of living longer term on the military spouse. Reasons for the lack of early details in the military spouse experience could be due to the data collection methods employed by the quantitative studies; including a wide range of standardised questionnaires such as the Marital Problem Index, Relationship Problem/Assessment scales (Riggs et al., 1998; Jordan et al., 1992; Allen et al., 2010; Renshaw and Caska, 2012; Campbell and Renshaw, 2013; Martinez, 2018). Whilst the results of these studies indicated impact on the relationship through statistical analysis of the responses to the tools used, they did not provide in-depth insight into the relationship or give opportunity for participants to share in detailed experiences at specific time points. Within previous qualitative studies, specific time points were identified - such as following diagnosis of Post-Traumatic Stress Disorder (PTSD) which, while useful for providing an insight into the time post diagnosis, fail to explore the time before a clinical diagnosis was made (Lyons, 1999; Iniedu, 2010; Woods, 2010; Mansfield et al., 2014; Brown, 2015; Temple et al., 2017; Waddell et al., 2016; Yambo et al., 2016; Thandi et al., 2016; Waddell et al., 2020). Whilst my study findings also recognise the spouses' experiences post diagnosis, they also provide an in-depth insight into the period preceding diagnosis and indeed, the motivating factors which led to help-seeking (I discuss this further below 224).

The initial emotional and physical symptoms of the veteran or serving partner's anxiety disorders, depression, dissociative disorders, adjustment disorders or PTSD, are well documented across the literature; however, the effect on the military spouse is neglected (Trivedi, 2004; Ahire, 2012). Few studies detail symptomology from the military spouse perspective (Brown, 2010). Physical symptomology of mental health issues and associated behaviours often act as triggers of concern for military spouses (Dekel & Monson, 2010; Nayer et al., 2013; Asnaani et al., 2014). Hyperarousal, hypervigilance, sleep disturbances and heighted startle reactions are common and can produce overreactions to safe situations that the individual perceives as dangerous. Within the literature, hyperarousal, hypervigilance and night terrors are well documented and are found to be commonplace for those serving personnel returning from deployment and veterans with diagnosed PTSD (Woods, 2010; Dekel & Monson, 2010; Nayer et al., 2013; Asnaani et al., 2014). These are used as umbrella terms to describe behaviours; however, examples of what constitutes these behaviours are not always explicit. Whilst the current study did not specifically explore PTSD per se or the post deployment period specifically, findings highlight a description of the physical responses to triggers which are suggestive of being in a hyper-aroused or hypervigilant state. Such behaviours were explicit in participants' stories in my study as they shared the different ways in which their serving partners' behaviours illustrated their emotional suffering. A noteworthy observation is that these behaviours were highlighted by the participants as causes for concern prior to a clinical diagnosis, unlike the existing literature which highlight these as behaviours post clinical diagnosis (Woods, 2010; Dekel & Monson, 2010; Nayer et al., 2013; Asnaani et al., 2014).

Substance misuse, specifically alcohol, is widely reported, with substantive literature (Milliken et al., 2007; Jacobson et al., 2008; Bray et al., 2013; Green et al., 2014; Hunt et al., 2014; Klanecky et al., 2017; Vest, 2018) suggesting that military personnel are at greater risk of heavy alcohol use and/or binge drinking. Likewise, the risk for those who have experienced exposure to combat have higher rates of alcohol use than those who have no combat exposure (Bray et al., 2013; Klanecky et al., 2017). Klanecky et al. (2017) reported that a spouse/partner presence had a moderating effect on serving/veterans partners' depressive/PTSD symptoms and alcohol consumption. Due to the nature of my study, I did not ask specific questions around drinking and the units consumed, however excessive use of alcohol was evident in my findings; so, whilst contrary to Kalnecky et al.'s (2017) finding, it was not unexpected. Interestingly within my study, the revisiting of images, media and war documentaries was noted; this behaviour is also indicative of hyperarousal as suggested in studies outside of the military setting (McKinnon et al., 2020); but there is no reference to this behaviour in the literature specific to the military. One reason for this may be because it is a less common behaviour or one that is overlooked and deemed acceptable because of the serving partner's career choice.

Re-establishing communication between the couple can be difficult on return from deployment. This can result from discussing or not discussing the events during deployment, making comparison of hardship during deployment and avoiding confrontation by concealing true feelings (Deployment Information and Resources, 2010). Lowe et al. (2012) and Cabrera-Sanchez & Friedlander (2017) recognised that this might result in uncomfortable interactions and that intimacy may take time to resume. When full communication and intimacy does not resume after a few months, relationship uncertainty prevails over the emotional and social disconnect (Thandi et al., 2016). Boss (2007) conceptualised this disconnect as the concept of ambiguous presence. Families experience loss in the post deployment stage by describing how the serving partner is '*perceived as physically present but psychologically absent'* (Dekel & Monson, 2010, p305). Findings in other military and veteran literature also emphasise communication and intimacy difficulties (Hendrix, 1998; Sherman et al., 2008; Iniedu, 2010; Woods, 2010; Campbell and Renshaw, 2011; Mansfield et al., 2014; Brown, 2015; Waddell et al., 2016; Thandi et al., 2016; Waddell et al., 2020; Brickell et al., 2021). Thandi et al.'s (2016) findings (currently, the only other UK specific study of military spouses to serving personnel), also recognised the emotional disconnect and impact on the intimate relationship. They identified '*intimacy'* as a key theme and, when their study was published, were the only authors to describe intimacy changes as both physical and emotional. Complimenting Thandi et al.'s (2016) findings, my study too demonstrated the range of different physical and emotional intimacy experiences. Like Thandi et al. (2016) study, my findings highlight that there is no universal behaviour that is indicative of emotional disconnect between couples; it is demonstrated through a range of behaviours.

Recurrences and/or the longevity of a mental health issue inevitably impact on day-to- day living. Again, my findings illustrate many parallels to existing military spouse literature as the findings move away from describing the initial period of the relationship. However, whilst such parallels exist in terms of the topic themes or categories, my findings represent the relationship prior to, as well as the relationship subsequent to, diagnosis. Throughout the existing literature, there is a predominate focus on negative connotations around the spouse experience (Verbosky and Ryan, 1988; Allen et al., 2010; Iniedu, 2010; Campbell and Renshaw, 2013; Brown, 2015; Murphy et al., 2018; Brickell et al., 2021; Johnstone and Cogan, 2021). Indeed, negative connotations featured within my findings with participants likening their experiences to '*being on a rollercoaster*;' because of the unpredictability of the trajectory of their partner's mental health issue., As well as the unpredictability over time, the unpredictability of the serving partners' negative behaviours day-to-day also took their toll on the participants. A unique finding within my study highlighted the extent to how the serving partners' mood (whether positive or negative) influenced the mood of the participant. It is also worth noting that some of the participants highlighted that they themselves did at some point also develop a metal health issue. However, only one participant made it explicit that their mental health issue was as of a direct result of their serving partners mental health issue. Most participants recognised how their mood was lowered if their serving partner was having a bad day which led to them feeling frustrated, angry and resenting their partners. Similarly, to Brown's (2015) study, the word *'anger'* was used by participants in my study to describe how they felt in response to a range of behaviours by the serving partner. An additional finding in my study, however, was that the opposite also occurred; that is, if the serving partner was experiencing a '*good'* day, participants said they felt relaxed, happy and positive. Changes in personality and the uncertainty of the serving partners' moods also led to participants in my study experiencing increased anxiety. Similarly, Temple et al. (2017) reported their participants' sharing their anxiety when thinking about their husbands return home; they expressed this through the quote '*not knowing what type of mood their husbands were going to come home in or what emotions they would bring through the door*' (p170). There were comparisons between my study's findings and those from the wider literature, especially Brown's (2015) study on the transformative experiences of military wives whose husbands were wounded in combat. Brown's (2015) study explored how military spouses made meaning of their new life resulting from the challenges of living alongside their wounded partner through transformative learning. In my study, the idiom '*walking on eggshells'* was used by Sara and Vikki to describe their experience of living alongside their serving partner during a mental health issue. Interestingly, the same idiom was used by Mansfield et al., (2014) and Temple et al. (2017) in their studies of military spouse experiences of living alongside veterans with PTSD; indeed, I chose the expression within my own story, written before I commenced data collection (See chapter 4). Participants in my study expressed a myriad of feelings - such as anger, frustration, loneliness, and worry – mirrored across the studies by Verbosky and Ryan (1988), Iniedu (2010), Woods, (2010), Brown (2015), Murphy et al. (2018) Brickell et al. (2021) and Johnstone and Cogan (2021).

Also similar to existing literature, (Waddell et al., 2016; Temple et al., 2017; Murphy et al., 2018; Brickell et al., 2021;) work pressure was voiced by some participants as a factor in triggering the serving partner's mental health issue; however, in my study the focus was the effect it had on the non-serving partner. My findings highlight the emotional pressures which arose from the distraction and worry that their serving partners' mental health issues caused them; for example, necessitating the participant to leave work to attend hospital or to leave the children with their serving partner whilst they worked or worried about what they would find at home when they returned from work. In contrast, other participants saw work as an escape.

The predominant focus in previous research pertaining to work was the lack of finances due to changes in work hours of the military spouse because of caregiving or from the inability to work by the veteran. Much of the existing literature was based in the US and/or with veterans (Waddell et al., 2016; Temple et al., 2017; Murphy et al., 2018; Brickell et al., 2021); so, whilst giving a valuable insight, it is not fully transferable to the UK, because income streams for sickness, such as benefits, sick pay are non-comparable between the two countries. However, Thandi et al.'s (2016) study, too, (which, as noted earlier, is currently the only other UK paper comparable with my study in terms of subject, methodology and scope); identified the financial strain on the military spouse, caused by the uncertainty about the longevity of the injury their serving partner had sustained. My study, as highlighted above, found it was the emotional pressure felt through worry and concern for their serving partner that participants described, rather than financial pressure which impacted on the relationship/participants' feelings of stress or concern. My findings may have differed from Thandi et al.'s (2016) study because the cohort of participants in Thandi et al.'s (2016) study were military spouses of MOD registered wounded, injured or sick personnel; some of whose conditions may have been severe, meaning they would ultimately be medically discharged. My study specifically looked at common mental health issues, adjustment disorder and PTSD, most of which can be managed through medication and therapy and would not require medical discharge; the MOD sickness pay policy would continue to provide a full wage for those who are wounded, injured or sick but remain employed.

Within my study, there was no specific focus on children; however, those participants who had children, shared stories about their children's experience during the time of their serving partner's mental health issue. Despite the age ranges of the children (adult through to pre-school age), participants described some negative impact on all, except for those children who were pre-school age; for example, Harry's two children (under the age of three) who seemed unaware of Nicole's post-natal depression. During the interview, Harry had shared how Nicole was secretive and tried to hide her symptoms from everybody not just the children. Similarities surrounding the concern for children and subsequent negative impact on children by serving partners' disruptive behaviours are found elsewhere (Jordan et al., 1992; Brown, 2015; Temple et al., 2017).

Analysing the military spouses' experiences facilitated understanding of their role during their serving partners' mental health issues, as well as illustrating what effects this had on the relationship. My findings demonstrated how the participants tried to '*fix'* their serving partners' mental health issue and, in some cases, their marital relationship. They also illustrated the participants, and their serving partners', attempts at help seeking. A common category from all the participants' stories was an inherent need to *'fix it'; 'it'* being either their current situation of living alongside their serving partner with a mental health issue or the mental health issue itself, or both. Whilst participants felt that action was required to determine a resolution for the mental health issue, central to this was a blend of feeling the need to help and needing the knowledge to be able to help which, for most participants, led to them feeling that their help, support and interventions were insufficient.

Underpinning the feelings of wanting to *'fix it'* was the participants' commitment to either their serving partner and/or their relationship. For participants, it was all about finding or providing the emotional and sometimes, physical solutions, to aid the serving partner. In previous studies, dedication, loyalty and commitment to the relationship was noted (Lyons, 1999; Sherman et al., 2008; Iniedu, 2010; Woods, 2010; Mansfield et al., 2014; Brown, 2015; Johnstone et al., 2021). A study of military spouses of UK veterans expressed that they simply needed to 'b*e there to sort them out*' (Johnstone, 2021, p63). A maternalistic instinct was noted in my findings (Christina, Simone, Sara and Sophie) which could be likened to a need to be nurturing and caring as found in Verbosky and Ryan (1988) and Thandi et al.'s (2016) studies; however, the motivation differed slightly in that, previous studies found it was the lack of intimacy driving the military spouse interventions, rather than an inherent, holistic need of trying to fix their partner (see later discussion on page 230). In addition, and contrasting from my findings, Thandi et al.'s (2016) findings also highlighted the '*transition from partner to carer'*, a possible explanation for this could be linked to the medical issue of the serving partner. The serving partners medical issues varied, not all were issues surrounding mental health. A proportion of the sample were military spouse of serving personnel with physical injuries which subsequently resulted in physical demands being placed and physical care been given in response for example one of their participants states:

> *‘It is affecting me a lot because like you can imagine how heavy he is so (laugh) and I’m a very slim person so (laugh) it’s quite really hard’* (Thandi et al., 2016, p5).

Most of the existing military literature does not highlight the non-serving partners’ motivation as being the desire to nurture and care; however, it does make explicit reference to care burden (See chapter 2). Across the wider non-military spouse literature, care burden dominates (Tranvag and Kristoffersen, 2008; Weimand et al., 2013; Penning and Zheng, 2015; Juntunen et al., 2017; Phillips et al., 2022). Whilst not specifically alluded to by any of my participants, it could be argued that some of my findings could be likened to some aspects recognised as caregiver burden. Zarit et al. (1986) defined caregiver burden as the extent to which caregivers perceive their emotional or physical health, social life, or financial status to be affected by their caring for an impaired relative. Vitalinao et al. (1991) suggested that the concept of caregiver burden includes both an objective element - such as strained relationships, financial constraints - and a subjective element - such as the reactions and responses as a result of the demands placed on them; all of which are associated with caring for someone with a long-term physical or mental illness. As suggested earlier, the last twenty years or so has seen the notion of caregiver burden applied to the spouses of combat veterans with PTSD (Cuijpers and Stam, 2000; Arzi et al., 2000; Calhoun et al., 2002; Dekel et al., 2005b; Manguno-Mire et al., 2007). However, as seen before, what was notable in my findings was that none of the participants perceived themselves as a caregiver, no references were made, nor implied that they felt or believed that they were their serving partner’s carer. One reason may be that spouses who live with a partner with '*transitory*' mental health issues may be less likely to see themselves as carers since there are often long periods of 'remission' when all is well. This is evident from my study’s findings and is demonstrated in the conceptual illustration of the U-curve journey.

Chapter 1 of this thesis highlighted the promotion of family inclusion in the treatment for someone with a mental health issue. This is widely accepted in the UK as it enables those living with them, an opportunity to gain knowledge of the issue and understanding of when and how to intervene and manage their loved one (NICE guidelines, 2005, 2011, 2014, 2015, 2021). In the military spouse literature, spouses’ knowledge and management of their partners’ symptoms was a notable theme; however, within all these studies, the mental health issue in question was PTSD (Sherman et al., 2008; Buchanan et al., 2011; Yambo et al., 2016; Temple et al., 2017; Murphy et al., 2018). My study did not just focus on PTSD, it also included other mental health issues such as depression, adjustment disorder. Similar to the existing literature, knowledge and understanding around the mental health issue and how to manage their serving partners' symptoms was evident in my findings, as seen in the sub-category '*I'm not trained in that, I don't know'*. Lauren voiced lack of formal training in mental health issues, whereas other participants used media sources and the internet to increase their knowledge; drawing parallels to Buchanan et al.'s (2011) findings. Findings from my study and across other military spouse studies, indicated that non-military spouses were unprepared to handle their serving partners' mental health conditions and/or deal with the complexity of the symptoms (Sherman et al, 2008; Yambo et al., 2016; Thandi et al., 2016*;* Temple et al., 2017). Findings from Shermans et al.'s (2008) study highlighted military spouses' lack of understanding regarding their veteran partners' functioning, resulting in barriers to communication between the couple and mirroring participants' experiences in my study. Thandi et al.'s (2016) UK study of military spouses of serving personnel '*described how the participant felt ill-equipped to perform the role as caregiver'* (p2). A notable point in my findings as described earlier, was that none of the participants ever related or identified themselves as the 'caregiver'. Some participants, however, expressed feeling ill-equipped; uncertain about whether to intervene and questioned their usefulness or whether they had been the cause of a negative reaction or response during their partners' mental health issue. These worries reflected those that were disclosed during Spencer-Harper et al.'s (2019) UK study exploring the experience of military spouses of veterans attending a psychoeducation group.

The sense of helplessness and uncertainty dominated the subcategory '*I've done as much as I can do*' which, again, is similar to some aspects identified in the care burden literature. My findings showed that many participants had reached a point where they no longer knew what else to do to help their serving partner. This, in turn, threatened the marriage and a deterioration in the relationship was felt. Throughout the military spouse literature, it is evident that PTSD symptoms and their severity had a major impact on the marital relationship (Riggs et al., 1998; Jordan et al., 1992; Iniedu, 2010; Mansfield et al., 2014; Brickell et al., 2021). The impact of the mental health issue on the miliary spouse was explicit in my findings; however, no parallels can be drawn regarding symptom severity. This could be due to differences in the studies; unlike the other military spouse research cited above, my study did not specifically explore PTSD, but was concerned with mental health issues generally and focused on serving personnel rather than the veteran population. The focus was on the more common mental health issues which, when managed or in remission, allow for the serving partner to continue working. The deterioration of the marriage and the desire to want to escape or leave the relationship was evident in my findings, as was the ongoing inner struggle that prevailed in the participant as to whether to go or stay. These are consistent with the findings in existing military spouse literature (Lyons, 1999; Iniedu, 2010; Woods, 2010; Mansfield et al., 2014; Brown, 2015).

While the majority of factors for wanting to leave the marriage were comparable to my findings, domestic violence as discussed by Kwan et al. (2020) did not compare and was not voiced by any of my participants. Children were both a factor considered for leaving (Sara, Lauren) as well as reason for staying (Cathy). Fisher (2004) purported that when couples raise their children as a team, the children then become a protective factor by being a barrier to leaving the relationship. Despite the desire to leave (two participants had a temporary separation) unlike Thandi et al.'s (2016) UK study, where some of their participants left the relationship all the participants in my study stayed in the marriage. Again, this is comparable to the existing literature in the field (Lyons, 1999; Iniedu, 2010; Woods, 2010; Mansfield et al., 2014; Brown, 2015). Comparable to the wider literature surrounding carers (Kulhara et al., 2012; Bauer et al., 2013; Weimand et al., 2013; Penning and Zheng, 2015; Juntunen et al., 2017;), the participants in my study said they had not left the marriage due to guilt, love, a sense of obligation, and fear that their serving/veteran partner would worsen or simply that they felt leaving wasn't an option. As noted earlier, some of Thandi et al.'s (2016) participants stayed in the marriage. Comparable to my findings they highlighted love and strength as a reason for staying. However, in addition Thandi et al. (2016) identified resentment as the reason for marriage breakdown and subsequent separation.

Up until this point in the participants' journey, my findings suggest that there was a period of time in which the participants and their serving partner were living with/trying to resolve the mental health issue, before seeking any form of formal support. Delay in help seeking was evident for both the military spouse and/or their serving partner ((Vogt, 2011). There was an element of containment within the family unit which could be attributed to a number of reasons; stigma (see chapter 3), not recognising symptomology or fear of repercussions – all of which have been noted in other literature (Buchanan et al., 2011; Lowe et al., 2012; Mansfield et al., 2014; Coleman et al., 2017). Lowe et al. (2012) recognised that:

> *'Seasoned dependent spouses may have come to understand the unique double-bind faced by military families and prefer to handle their stressors privately and without available services simply to avoid any negative career ramifications associated with disclosure'* (p24).

In my study, the category *'seeking support'* highlighted a number of avenues for support, these were either formal, provided by professionals; or informal, by family or friends. Consistent with the findings of Buchanan et al. (2011), Coleman et al. (2017), Temple et al. (2017) and Johnstone & Cogan's (2021) studies of military spouses of serving personnel, my findings suggested that the notion of reaching out to others and accessing mental health care services was perceived with caution. The point at which formal support was accessed by the serving partner was usually when the participants had reached a stage when they felt they could no longer help. Current literature suggests that it is the spouse more than other social influences such as peers, friends and other family members who persuade or motivate their serving/veteran partner to seek help (Burnett-Zeigler et al., 2011; Klanecky et al. 2017). Klanecky et al. (2017) identified that military spouses can be indirectly involved in assisting the acquisition of strategies to aid their serving/veteran partner by encouraging veterans to seek treatment. This was similar to my findings, participants encouraged or motivated their serving partner to seek support; however, in some cases, this was by using the veiled threat of contacting military services themselves. As touched on earlier (Chapter 3 and 6), a military spouse contacting the services is perceived to be a negative behaviour by other military personnel and likely to have caused the serving partner an element of worry. It could be argued that military culture is at play here. As discussed in chapter 3, cultural expectations within the military exist; however, there are accounts where military spouses have challenged, negotiated or threatened the military institution to initiate support for themselves and/or their serving/veteran partner (Harrison & Lalibert´e, 1993; Enloe, 2000; Brown, 2015; Gray, 2017; Long, 2021).

Once formal support had been accessed, experiences differed between the participants in my study; for some the effectiveness of formal support specifically focused on their serving partner, was viewed as positive. This is consistent with the findings of Verey et al.'s (2017) UK study; that inpatient medical care was effective for both the serving person and their families (this included spouse, parents, children, siblings); but that in the community following discharge, the formal support varied. For other participants in my study, the findings indicated that the spouses deemed their serving partners experience of medical support ineffective, slow to respond and that they had difficult therapeutic relationship with healthcare professionals.

Findings from my study showed that other formal provision - such as MOD welfare services - whilst available for the serving partner, offered little support for military spouses or their wider families. This appears to be consistent with current literature; there are multiple papers internationally with some specific to the UK (Iverson et al., 2010; Bull et al., 2015; Keeling et al; 2017; Sparrow et al. 2020) highlighting the involvement of welfare service and serving personnel. However, there are minimal papers especially in the UK (Verey et al. 2017), focusing on the support offered to military spouses. As described in chapter 6, Military welfare services in the UK are provided by the MOD to support serving personnel and their families. The responsibility for primarily promoting the welfare service to military families lies with the serving member and is outlined in MOD policy (2014). Any lack of awareness of service provision from the perspective of the military spouse or family is then attributed to their serving partner.

In my study, participants who experienced some contact with welfare services felt that they were not really focused on the family and, for the most, their experience was negative with little support. Some participants felt uncomfortable even accessing military welfare services; beliefs included lack of confidentiality, and by whom it was being delivered by. As highlighted in chapter 6, such beliefs are misconceived. As per an earlier discussion, for spouses who live with a serving partner with a '*transitory*' mental health issue, the connection with services, too, may be '*transitory'* as they would be removed from the wounded, injured and sick (WIS) register in times of remission. In times of recurrence, they would need to engage with the services again, meaning, they then have to '*start again*' terms of seeking support when their serving partner becomes ill again. The lack of consistency and identified point of contact. Verey et al.'s (2017) findings from a UK study exploring military family support needs recommended a '*family care co-ordinator role'* positioned to liaise directly with families. This kind of role was something that was voiced by a few of my participants when they described what would have helped them. Murphy et al. (2018)'s study focusing on military spouses of UK veterans also explored participants' desired type of support and barriers to support. Their findings mirrored other research in that military spouses felt that sharing experiences with '*fellow experts' who they saw as peers, was crucial for 'reassurance, normalisation and confidence'* (p6). The vast majority of literature surrounding a range of peer/professional interventions was based in the US, and predominantly explored group or couple therapy (Dekel & Monson, 2010; Fredman et al., 2011; Sayers, 2011; Blow et al., 2015). Two UK studies offered conflicting findings; Murphy et al.'s (2018) findings suggested caution against group settings for support with or without the veteran partner since such interventions were felt to be restrictive and spouses were unable to fully express themselves. In contrast, Johnstone and Cogan (2021) promoted the use of group-based interventions for the connections formed by the participants.

The findings surrounding informal support were similar to the findings of formal support in my study. Most participants alluded to family and friends as mechanisms of support. Some shared positive experiences and others were deemed more negatively with practical barriers to support - such as distance from family - were highlighted. Similarities were noted in Murphy et al.'s (2018) study; however, their paper failed to differentiate between formal or informal support. Murphy et al. (2018) and Brickell et al.'s (2021) studies found that military spouses felt that others (family and friends) who had not experienced living with a military partner with a mental health issue, simply could not understand what it was like. Some participants in my study concurred with this but, for others, having support from peers or others with similar understandings of the military culture was valued, which again, is consistent with other literature (Verey et al., 2017; Murphy et al., 2018; Spencer-Harper et al., 2019; Jones et al., 2019). A notable point here is that my participants sought peer support independently through acquaintances and friendship. None of the participants alluded to attending or having any awareness of any established peer support groups with an identified focus.

Whilst peer support across the military community is widely acknowledged, the perceived stigma surrounding mental health issues and/or the inability to cope from either the perspective of the military spouse or the serving partner is also largely documented in the literature (Murphy et al., 2016; Verey et al., 2017; Murphy et al., 2018; Long, 2021) (See chapter 3). Likewise, there is much literature surrounding the stigma-related barriers towards help-seeking for the treatments of PTSD and other mental health issues (Vogt, 2011; Corrigan et al., 2014; Sharp et al., 2015; Sharp et al., 2015; Brown, 2015; Coleman et al., 2017; Temple et al., 2017; Verey et al., 2017). Previous studies have found that mixed messages received from military units whereby adverts around camp promoted positive messages, yet direct actions such as help seeking were viewed as negative and feelings of being silenced by other military personnel (Brown, 2015; Murphy et al., 2016; Temple et al., 2017; Verey et al., 2017). My findings corroborate these findings; participants reported that living within the confines of military culture, there continues to be stigma surrounding mental health issues. This is not only perpetuated within the confines of camp, but also within the wider context of military families themselves. As a result, such stigma continues to reinforce the prevailing military culture of stoicism (as discussed in chapter 3) and highlighted by both Coleman et al. (2016) and Murphy et al. (2016).

One of my study's s objectives was to investigate the experiences of the military spouse whose UK serving military partner had sought or received treatment for a mental health issue. As discussed in chapter 1, mental healthcare provision for UK serving personnel is provided in-house by Defence Medical Services (DMS) whose services are aligned to and delivered, following the same policies and guidance as the National Health Service (NHS). There is an explicit requirement for the serving person to recognise the mental health issue in themselves and self-refer into services. As highlighted earlier, this is fraught with concern as many people experiencing a mental health issue do not recognise it (Britt et al., 2012; Mellotte et al., 2017; Coleman et al., 2017); earlier identification is more often seen by those around them. This is reinforced through the findings of my study; Sophie spoke of the MOD's duty of care, believing that they should be pro-active, stepping in when a mental health issue is identified. Whereas for other participants, the point at which the serving partner accessed formal support was a result of pressure imposed by the military spouse. This pressure is recognised in other military studies where spouses and other family members have been identified as the key enablers for help seeking (Warner et al., 2008; Sayer et al., 2009; Stuttaford, 2020). Given this and the stigma surrounding mental health issues in a military context, it was surprising that the point of diagnosis was not discussed by the participants in my study in more depth. Very few of the participants spoke about the point of diagnosis and, even then, only briefly.

Evidence suggests that having a diagnosis, helps with treatment seeking, provides reassurance and allows individuals with mental health issues to communicate their feelings and difficulties (Craddock and Mynors-Wallis, 2014; Mellotte et al., 2017). The lack of emphasis by participants in my study surrounding the diagnosis, might have been because they had been living with their partner's mental health issue for so long prior to the diagnosis that, at that point of telling their stories, it was felt not so important. Also, because there is no joint access to DMS and, for most, the serving partner attended appointments alone, the '*protective buffering'* by the serving partner (Skomorovsky et al. 2022) and the lack of emphasis on reinforcing spousal support from the clinical practitioners, could go some way to understanding why there was little disclosure about the diagnosis. Much of the military spouse literature does not include the point of diagnosis. Similar to my earlier findings about the initial noticing stages, the majority of the participants' detail is on impact post diagnosis; the actual point of diagnosis is not discussed. On review of the wider literature surrounding military personnel and also outside of the military context, my findings illustrate a similar pattern with either minimal exploration at the time of diagnosis (Mellotte et al., 2017) or that much of the exploration involves experiences post clinical diagnosis (Sautter et al., 2006; Iniedu, 2010; Daniels, 2013; Brown, 2015; Thandi et al., 2016; Waddell et al., 2020).

Whilst an objective of this study was to explore the experiences of military spouses whose UK serving military partner had sought or received treatment from mental health services, there was not a specific objective to review services received by the serving partner. Inevitably, the range of treatments and care plans were alluded to but, again, only briefly. Positive responses to treatment were shared by some participants; however, it is worth noting that some of the treatments were sought independently outside of DMS. A further finding was the serving partners' disengagement with their treatments which presented a concern for some military spouses. Disengagement was through failing to attend appointments or failing to take medication. This behaviour could be indicative of self-stigma or internalized stigma, where the individual experiencing a mental health issue '*internalises negative stereotypes and prejudices held by the general public'* (Vogt, 2011) (see chapter 3). Evidence suggests a prevalence of internalised stigma regarding mental health issues within the armed forces (Greene-Shortridge et al., 2007; Vogt, 2011; Zinzow et al., 2017; Coleman et al., 2017). Indeed, Pury et al. (2014) purported that within the armed forces, the most frequent internalised stigma beliefs are '*I am crazy', 'I am weak'*.

My findings highlighted that not only were military spouses concerned by their serving partner's disengagement from support and treatment, but they were also concerned about their exclusion from any treatment/therapy plan. As discussed in chapter 1, it is widely accepted throughout the National Health Service (NHS) that the inclusion of the family in the treatment of a client with a psychological illness can aid recovery and provide vital support in managing the condition for both the client and their family. Family inclusion was explicitly documented in NICE guidelines (2005, 2011, 2014, 2015, 2022) and was also mirrored in some of the military literature, which emphasised how influential the partner's role was to treatment outcomes (Monson et al., 2005; Murphy et al., 2016;). Likewise, having the opportunity to liaise with medical or other trained professionals, along with greater involvement in their serving/veteran partner was reflective of the military spouse literature (Mansfield et al., 2014; Brown, 2015; Murphy et al., 2018). As DMS mirrors the care provided by the NHS, it could be assumed that families would be supported and be included in the care during a serving partners' mental health issue. In practice, my findings suggest that there was little or no inclusion of the military spouse during their serving partner's treatment episode. This finding is comparable to other military spouse literature and reports which also proport a lack of inclusion (Research and Development Corporation, 2014; Mansfield et al., 2014; Waddell et al., 2016; Verey et al., 2017; Waddell et al., 2020; Johnstone and Crogan, 2021). Indeed, both Mansfield et al. (2014) and Johnstone & Crogan (2021) voiced a '*sense of being invisible, forgotten and overlooked'* (p45). However, within the literature, only two studies were specific to the UK. One had a focus on military spouses of veterans, meaning differences in the healthcare providers and therefore not comparable to my study. The other, Thandi et al.'s (2016) study, whilst similar to my study in that the focus was on serving personnel, the research itself was centred around both physical and emotional issues under the remit of 'wounded, injured and sick' (WIS) and was inclusive of all family members (spouse, parents, siblings, children); therefore, drawing any meaningful comparisons with my study was problematic.

Moving towards relationship balance

The period of relationship discontent illustrated in my study enables a deeper understanding into the challenges faced by military spouses when living alongside their serving partner during a mental health issue. As highlighted earlier in the discussion, when there is disruption within the relationship, it can threaten, alter, or transform a marital relationship (Cabrera & Aya, 2014). However, despite the challenges imposed on the marital relationship, comparable to the wider carer literature (Phillips et al., 2022), my findings showed there were also enablers which supported a growth in resilience. Similar to the positive and rewarding aspects of caring, such as inner strength, personal growth, self-confidence, a sense of increased gratitude, satisfaction & compassion identified in the wider literature (Kulhara et al., 2012; Bauer et al., 2013; Phillips et al., 2022); for the most, these aspects sustained the marital relationship, ultimately leading to a balance, as identified in the U-curve journey.

A key finding, which would not have been considered had only category-content analysis taken place, is that of the participants' recall of the strength and positivity of their early relationship visible in the findings from the holistic-content analysis in chapter 5. This finding is comparable to other literature which also recognised the positive feelings expressed by military spouses recollecting the past, such as early times in the relationship (Woods, 2010; Campbell and Renshaw, 2013; Brown, 2015; Thandi et al., 2016; Martinez, 2018; Johnstone et al., 2021). Indeed, Johnstone and Cogan (2021) reported that military spouses cherished the good days, bringing about feelings of privilege and safety. The findings from my study saw most participants reflect on good times and positive aspects of their relationship. These were often in periods of remission where participants and their serving partner experienced an element of stability and normality in their relationship. Similar to Johnstone and Cogan's (2021) study, participants in my study alluded to positive times prior to their serving partners' mental health issue; predominantly, when their serving partner was mentally well. Indeed, early positive couple functioning was identified as one of the three levels of factors included in Goff and Smith's (2005) Couple Adaptation to Traumatic Stress (CATS) model which is a systemic model of the development of interpersonal symptoms in the couple dyad based on empirical literature. The early positive couple functioning factor was predominant in military spouse literature; therefore, the ability to retain these positive feelings of couple functioning may go some way to explain how they overcame the bad days. A further consideration is the reciprocal exchange theory in intimate relationships. Theory surrounding reciprocal exchange in intimate relationships is well established and has been theorised since the mid-1960s where both positive and negative reciprocity within relationships was recognised (Smith, 2002). Whilst similar in definition, the theoretical differences are distinctly different (Smith, 2002). Positive reciprocity in intimate relationships is underpinned by the promotion of trust and intimacy, initially built upon small risks, whereby positive acts are observed and reciprocated, thus building trust and motivating the relationship (Kelley, 1979; Rempel et al., 1985; Scanzoni, 1979). Smith (2002) suggests that as positive reciprocity transcends over time the intimate relationship becomes a communal relationship whereby the partners no longer monitor the positive acts; they are just willing to offer positive acts irrespective of the other's capacity to reciprocate. Conversely, negative reciprocity in intimate relationships is the exchange and defence of negative acts (Smith, 2002). Smith (2002) purports that negative reciprocity '*may often be readily apparent on a moment-to-moment basis*' (p12). There has been a plethora of studies exploring negative reciprocity with many concluding that whilst the majority of intimate couples will experience negative reciprocity at some point, distressed couples will likely reciprocate negative responses immediately, opposed to non-distressed couples (Gottman et al., 1976; Billings,1979; Cousins & Vincent, 1983 analysis 2; Krokoff et al., 1988; Levenson & Gottman, 1983; Levenson et al., 1994; Gottman et al., 1998). It could be proposed that the acknowledgement of the early relationship and experience of good days in amongst negative experiences, sustained the relationship during the mental health issue. However, this conflicts with early non-military spouse literature which suggested that marital dissatisfaction and disruption persists even during times of remission (Rounsaville et al., 1979; Targum, 1981; Fadden et al., 1987; Mannion, 1996). One study by Targum et al. (1981) indicated that over half their participants would not have married their partner had they known of the mental health illness. The difference in the military literature could also be attributed to a range of reasons such the strength of bond formed in the early relationship, the stoicism evident in the military culture (see chapter 3) or conversely, financially driven especially when SFA utilised.

Potential recurrences

Despite recognising the good days, there was recognition by participants in my study, that their serving partner's mental health issue was in some way always there. Whether during a recurrence, difficult episode or remission, the participants' resilience appeared to strengthen. Within the findings, participants did not have one overarching strategy for living alongside their serving partner. Similar to other military spouse research, (Monson et al., 2009; Dekel & Monson, 2010; Campbell et al., 2017; Spencer-Harper et al., 2019), the majority of my participants recognised various protective strategies of adjustment in themselves. This was either through avoidance or accommodation when responses or behaviours were present, and /or the adaptability within the marriage in order to '*survive'* and cope with the day-to-day experience of living alongside their serving partner. The need to adapt and adjust strategies in order to cope is, in some ways, not a new experience for military spouses; the military lifestyle requires an element of adaptability. Long's (2021) study identified the requirement for the military spouse to continually adapt strategies in response to deployment requirements. Whilst acknowledging some transferability of these findings to my study, there are contextual issues to consider here; for example, deployment has a completion date, a mental health issue does not.

My findings indicated how the participants themselves adjusted to their serving partner’s disruptive behaviours, either through avoidance or accommodation. Similar to evidence purported by Spencer-Harper et al. (2019), some of my participants used avoidance and took themselves away from their serving partners disruptive behaviours as survival strategies. Whereas and Monson et al. (2009) Dekel and Monson’s (2010) research described military spouses’ attempts to prevent their serving partner’s disruptive behaviour occurring by avoiding any situations that exposed ‘*trauma related stimuli or emotions’* (Monson et al., 2009, p711). Monson et al. (2009) also implied that by managing this kind of avoidance leads to the ‘*accommodation*’ of disruptive behaviours and the disorder; indeed, participants in my study shared how they accommodated their partners’ behaviours and accepted ‘*that is how it is’* and ‘*that is how it always will be’*. Similarities were noted in Brown’s (2015) study when she described the military spouses’ experiences as something that is ‘*just meant to be*’ (p276). Monson et al. (2009) recognised accommodation as the ‘*modelling of tolerance of negative emotional states*’ (p711). Campbell et al. (2017), however, warned against constant accommodation, suggesting greater distress for both military spouse and veteran partner in the long-term; this was certainly echoed by Lindy in my study (chapter 5).

The time between interviews in my study gave participants the opportunity for reflection as they attempted to make sense of their experiences. Bury’s (1982) seminal work conceptualised that a chronic illness (in his case rheumatoid arthritis) brought about a disruptive experience; this study identified similar patterns. The ‘*biographical disruption’* that the mental health issue had on day-to-day life, the impact felt by the individual (the spouse and the serving partner - individually and their relationship - and, at times, the wider family) and the interplay are all noteworthy findings in my study. For most participants, reflecting on their experiences highlighted a continued struggle as they battled with a range of emotions, anger, frustration, and heartache. Others seemed enlightened about how their relationship had adapted to ‘*survive*’. In sharing their experiences of early relationship (chapter 5); it was evident that there existed an element of mourning for the relationships they once had. For others, there was acceptance, or they were able to find positives in their rekindled relationship together. The findings from this study add strength to the existing knowledge within both the military literature (Johnstone and Cogan, 2021) and across the caregiving literature (Palacio et al. 2020); that, by adapting and securing a relationship balance of meaning and satisfaction, the relationship can be positively sustained through one partner’s mental health issue. Indeed, Johnstone and Cogan's (2021) military spouse study professed its '*the experience made us who we are'* (p65).

7.3 Strengths and limitations of the study

The findings are representative of the shared experiences of nine white British, military spouses living alongside their serving partner during a mental health issue. A strength of this study was that I was able to recruit military spouses whose serving partners came from differing ranks, both commissioned and non-commissioned, from a range of geographical areas across England. However, all participants were military spouses whose serving partners were from the army: no military spouses whose serving partners came from the Navy or Royal Air Force were represented. Whilst not recruiting from all of the tri-services is a limitation, the strength arising from recruiting from only one of the tri-services maintains more consistency in context within the stories.

One of the strengths of the study, was adopting a biographical approach. Using in-depth life story interviews (undertaking two interviews with each participant), the dynamic intricacies of the participants' experiences take centre stage and places the participant at the heart of the study. The strength arises from the insight and the knowledge gained from the stories of the individual experiences from a population who are very often marginalised, silenced or seldom heard, and hard to reach. This is evident, in that this study is only the second study of this kind in the UK.

Analytical pluralism, utilising the different dimensions in Lieblich et al.'s (1998) framework for analysis, enabled the participants' '*whole'* story to be voiced and also generated categories to be presented. Adopting different analytical approaches allowed me to produce rich data in context, I was able to draw out, not only specific episodes in time but create a journey trajectory.

Although a small sample size is expected in qualitative studies, a larger, less heterogenic sample of participants would have facilitated a greater insight into the wider '*significant other'* population of serving military personnel. Whilst the study was open to participants who were co-habiting partners, boyfriends or girlfriends, all participants were married, and to someone of the opposite sex. As a result, this study specifically focused on the insight and experiences of spouses: it does not represent '*significant others'* such as boyfriends, girlfriends, co-habiting unmarried partners, parents, or children. Furthermore, participants were predominantly female military spouses (n=8) with only one male spouse recruited and is not representative of those in same sex relationships. Having a larger representative sample of male spouses' and same sex spouses might have highlighted differences or shared similarities to female spouses' and allow for further insights to be made.

7.4 Recommendations arising from the study's findings

Recommendations for all mental health care provision and practice

Opportunity to be heard

Evident from the literature review and supporting theory in the discussion, the voices of spouses of partners with mental health issues remains an under-researched area. From the studies that have endeavoured to explore these experiences, the majority utilise pre-determined tools, inventories or questionnaires, leading to lots of box ticking as opposed to allowing voices to be authentically heard. There is a need to allow spouses the opportunity - with or without their partner - to tell their stories safely so that their experiences are captured and better understood. The approach taken in this study facilitated this and emphasises therefore, the importance of listening; not just in the context of research, but in the clinical/practice arena where practitioners and other care providers are best placed to provide such an opportunity.

Terminology used

As highlighted at the beginning of this study, the differing terms used within mental health provision regarding mental health conditions can cause confusion and misinterpretation. Many variations exist and are often used synonymously in the literature and policy - such as illness, disorder, problem, condition, and issue. A consensus surrounding the terms used within mental health practice would be useful for service users and their significant others, along with the general public in order to enhance communication and better navigate information, systems and services. For example, some terms such as disorder or conditions imply a definitive diagnosis, whereas issues or problems could be interpreted as a mental health issue without a diagnosis.

Recommendations specific to MOD service provision and practice

Recognition and inclusion of the military spouse

Despite UK practice guidance (NICE guidelines, 2005, 2011, 2014, 2015, 2021) promoting the inclusion of family in the care and treatment of individuals with a mental health issue, it would appear that DMS do not routinely involve family is the care of serving personnel. There is a need to support and include military spouses when providing care for serving personnel with a mental health issue because through inclusion, the uncertainty and lack of knowledge surrounding the symptoms, behaviours and management of the mental health issue could be addressed. This could go some way to protecting the relationship, the family unit and support recovery of the serving member. Identifying designated named personnel within the health or welfare services to initiate and be a point of contact, as well as listening to and sharing the family perspective could address the perceived barriers felt by military spouses.

Military culture

The complexity of military culture, stigma and the impact on help seeking, warrants consideration in future research and the development and delivery of policies and services. There is an identified need to challenge the military culture through consistent messaging across all ranks, departments, service provision and families. Misconceptions and incorrect beliefs – such as welfare service provision, mental health stigma - reinforced by inconsistency and fear act as barriers to accessing service and seeking early intervention and support.

Service provision

UK military welfare services are delivered in line with the Tri Service Operational and Non-operational Welfare Policy (MOD; 2014). Under this policy, it is not only the serving member that is supported but also his/her family. This study found that the quality of the intimate relationship between the military spouse and their serving partner is placed under enormous strain for the duration of the mental health issue. Support for the serving partner and their military family, should be provided by peers or organisations who understand military life. As such, the military welfare service is best placed to provide such support. Through the provision of early, accessible specialised support/counselling services. These services need to be inclusive of both parties - either individually or together as a couple. This could serve as a protective factor in addressing and exploring the couple’s emotional disconnect and promoting the serving partner’s recovery.

Recommendations for future research

One of the objectives of this study was to develop a deeper understanding of the military spouses' experience of living alongside their serving partner during a mental health issue. This study has raised areas for future research consideration:

The findings from this study highlight the lack of research specific to military spouses in the UK. This study represents one of two studies which exclusively focuses on the military spouses of UK serving army personnel during a time of illness. Unlike Thandi et al.'s (2016) study where secondary data was used to determine the effect of the WIS person's injury/illness on the relationship, this study specifically aimed to explore the experiences of military spouses during their serving partner's mental health issue. Further qualitative research in this area is required to facilitate greater insight and highlight commonalities in the military spouses/partners' experiences. The importance of such research will give insight into what is a huge resource of informal support for serving personnel and hence the military organisation; albeit an unpaid one (Stuttaford, 2020; Long, 2021; Gray, 2022; Skomorovsky, 2022).

There is a need to undertake similar studies across other military Tri-services, the Navy and Royal Air Force. Due to the lack of research specific to UK military spouses, and differences in work demands imposed on the different serving partner roles within the UK military, this is worthy of further attention to understand if the military spouses across the tri-services share similar or contrasting experiences.

Further to exploring the experiences of military spouses living alongside their serving partners with a mental health issue, within the UK, there is also a need to explore the avenues of support and supportive strategies such as peer led education and information sharing for military spouses. As identified in the existing literature and also my findings, having support from peers or others with similar understandings of the military culture was evident. However, the peer support identified by the participants was sought independently through acquaintance and friendship not by attending established, formal peer support groups with an identified focus. In the USA, there has been some studies which have explored a range of interventions with veteran and serving populations; however, given the differences in service delivery and provision makes transferability problematic. In the UK, exploration and evaluation studies of support are predominantly focused on the veteran population, whilst some support interventions may have relevance, having some UK studies specific to military spouses of serving personnel would be beneficial.

As highlighted in Chapter 6, very often, those individuals with a mental health issue do not necessarily recognise a mental health issue in themselves, and it is predominately people surrounding that individual who recognise symptoms and changes in behaviour. The military spouses within this study played a significant role in the help seeking behaviour of their serving partner. This highlights a concern for individuals who do not have a spouse or significant other and poses the question as to whether that support and negotiation to seek help is provided by other family members, friends or colleagues or whether they simply slip through the net, fail to receive treatment, or are discharged from the military due to exacerbation of behaviours; for example, alcohol abuse.

7.5 Original contribution to knowledge

This study provides the first in-depth exploration of military spouses' experiences of living alongside their serving partner with a mental health issue in the UK. Adopting a biographical approach has given a voice to the military spouse and the complexity of their situation. As this study is the first of its kind in the UK, several original contributions to knowledge arose. From those original contributions some have greater applicability within a UK setting, whereas some hold wider international relevance. Table 8 illustrates a summary of the original contributions to knowledge in military spouse research.

The range of symptoms and behaviours post diagnosis of a mental health issue, predominantly PTSD are well documented in the literature about military personnel and veterans and in some of the military spouse literature. Most of the literature is primarily based in the US; however, studies outside of the US have presented similar findings. The uniqueness within this study, is that whilst the range of symptoms and behaviours are akin to those found in post diagnosis studies, this study explicitly identifies them in the period leading up to diagnosis. This study recognises that those symptoms and behaviours prevail and present as causes for concern long before a diagnosis is made. Similar to the plethora of studies surrounding the symptomology and behaviours displayed by the serving/veteran partner, the negative connotations and caregiver burden felt by the military spouse in response to the serving/veteran symptoms is dominant in previous literature. Evident within this literature was the correlation between the severity of mental health symptoms and the caregiver burden felt. Again, most studies reside in the US, with the majority being spouses of veterans, post clinical diagnosis of PTSD. Within some literature positive connotations were documented although the emphasis was less than the negative connotations. Like the literature, this study found that the military spouses spoke of both positive and negative feelings in regard to their experiences. Comparisons were highlighted between the serving partners' good and bad days; however, original to my findings was how the serving partners good or bad days influenced or impacted on the mood status (positive or negative) of the military spouse.

Existing military research suggests that the accommodation of disruptive behaviours and adapting responses to disruptive behaviours by the military spouse is evident. The acceptance of behaviours and the mental health issue by the spouse is also highlighted in the wider carer literature. The findings in this study mirror these; acceptance by the military spouse that their serving partner's mental health issue never really goes away was evident. The adaption of their own behaviour so as not to inflame situations or accommodate their serving partner's disruptive behaviour for the sustainability of the marriage was recognised by the participants. The explicit nature of the military spouse changing their role in the relationship by accepting, adapting or accommodating, rather than expecting any changes from the serving partner for the sustainability of the marriage is distinctive to this study.

Throughout the military literature, the impact on work life is well documented especially in relation to the financial burden experienced; predominantly, this is caused by the military spouse having to leave or reduce hours in employment to care for their partner, travel costs to and from healthcare services or the uncertainty about the longevity of the injury their serving partner had sustained. My study identifies an impact on the spouses' work; however, the context differed from what has been highlighted so far in the literature. Exclusive to my study is the descriptions of the emotional pressure felt by the participant through their worry and concern for their serving partner whilst at work. This finding adds a contrasting view to what is already known.

The following three original findings have greater applicability to the UK as they relate to treatment and support. As suggested in chapter 1, the inclusion of the spouse/family in the treatment of mental health issues and, promotes recovery for the individual with mental health issues, reduces stress and anxiety for those living alongside the individual because they feel better equipped to manage situations at home. My findings like other studies that have gone before, identified that military spouses want more knowledge about their serving partner’s mental health diagnosis. Differing to the findings of US studies where spouses were included in treatment delivery, the military spouses in my study were not included in the treatment delivery, but they all expressed that they would have liked to be involved so that they felt better equipped to support their serving partner’s recovery. The original contribution emerging from my findings was that in the UK, military spouses feel invisible and are not routinely invited by the DMS to be included in the care plan or treatment of their serving partner.

Alongside the invisibility within the treatment delivery was the support or lack of support that the military spouses felt they received from MOD formal family support provision; specifically, the welfare services. In the UK, formal family support from MOD welfare services is promoted via the serving partner. To access formal support, the serving partner or family member must initiate contact. My findings suggested that formal welfare support is focused on the serving person. Spouses' unwillingness to access support arises out of fear of perceived repercussions on their serving partner and/or their partner’s career or that they themselves will be judged as not coping. My findings also suggested that lay misconceptions exist surrounding the training and experience of those soldiers delivering welfare services. As a result, what is exclusive to this study is a perceived lack of accessible confidential support for UK military spouses from military welfare services. When considering other avenues of support, peer support and the sharing of common experiences is well documented in US veteran literature. The studies proport the positive effects of such support and suggest it promotes resilience in military spouses. In contrast, my findings suggest that there was a reluctance by the military spouses to share with family or friends due to stigma, lack of understanding or being judged as not coping. This finding therefore highlights a further original contribution to existing knowledge that in there continues to exist, a stigma and fear of being judged within the UK military spouse population.

The final original contribution to knowledge is the whole journey trajectory. As highlighted, the majority of studies that explore military spouses’ experiences specifically focused on the experience and the impact felt post diagnosis. There are no studies that illustrate the experience of living alongside a serving partner with a mental health issue prior to diagnosis. The convergence of the two types of findings not only emphasize the early relationship but illuminate when things begin to change within the relationship, highlighting the symptoms and behaviours that initially cause concern. The findings also illustrate the time of diagnosis, treatment, and the return to a balance in the relationship. Unique to this study was the detail of experiences both pre and post diagnosis led to the generation of the U-curve journey; a conceptual illustration depicting the trajectory of the military spouse's journey of living alongside their serving partner during a mental health issue.

Table 8: Original contribution to knowledge

Original Contributions to knowledge	
1	The range of symptoms and behaviours present causes for concern to the military spouses *before* any diagnosis is made and support is sought.
2	The mood status (positive or negative) of the military spouse is affected by their UK serving partner's mental health status.
3	The sustainability of the marriage is pivotal on the military spouse changing their role in the relationship by accepting, adapting or accommodating rather than any changes by the serving partner.
4	The emotional burden felt by military spouses during their working day resulting in increased stress.
5	In the UK, military spouses feel invisible and are not routinely invited by DMS to be included in the care plan or treatment of their serving partner.
6	Highlights lack of accessible confidential support for UK military spouses from military welfare services.
7	Highlights continued stigma and fear of being judged within the UK military spouse population.
8	Generation of a conceptual illustration depicting the trajectory of the military spouse's journey of living alongside their serving partner during a mental health issue: the U-curve journey.

7.6 Dissemination of findings

Dissemination of the research is important, allowing the researcher to communicate their findings; this can occur through varied means (Keen and Todres, 2007).

Through two internal conferences, I have presented my literature review through a poster presentation (see appendix 15), and I have given a presentation about the use of Lieblich et al.'s (1998) framework for data analysis (see appendix 16). These conferences gave me the opportunity to receive feedback from peers at an early stage of analysis, allowing for further dialogue with the stories. On completion of my study, it is my intention to share the findings through local and national conferences via the Northern Hub for Veterans and Military Families Research and the Military Spouse Critical research network.

In recent months I have revisited the systematic narrative literature review and prepared the content for publication. This is currently under review with the peer reviewed journal Plos One. I have also started the process of revisiting the different areas of my study in preparation for individual publication and collaborative publication across a range of peer reviewed journals with an interest in military family research.

7.7 Final thoughts

On completion of the thesis, I shared the key findings with some of the participants; they spoke of the reassurance that had transpired by learning that they were "not the only one" to go through what they had experienced and felt. Similarly, this study arose from a personal experience where I questioned whether I was "the only one"! Having not resided within a military community or having any peers who were military (as I highlighted in the paragraphs at the start of the thesis), I felt alone and invisible. I embarked on my doctoral journey, a few years after my initial experience of living alongside my serving partner with a mental health issue and held the belief that we (me and my husband) had moved on from the experience with no lasting effects and that the impact had subsided. As seen in chapter 5, there is a uniqueness to each story but collectively (chapter 6) there is commonality in their experiences. As I come to the end of the study, it is this commonality that has led me to revisit my own experience. Whilst challenging it has helped me make sense of my experience and the continued vulnerability and anxiousness I sometimes feel. There remains a state of hypervigilance, and monitoring of mood and behaviours in the fear of a recurrence. I have also recognised that it has been me (like the participants) who has adjusted and indeed accommodated, a new way of living alongside a partner with a mental health issue who is currently in remission. As a final thought knowing that I am not the only one, (just like the participants) has given me reassurance, and the strength to keep going, facing out future together.

7.8 Chapter conclusion

This chapter presents the conclusion to this study. Initially, the discussion draws together the study's main findings, by abstracting them from the participants' perspectives to explore and better understand their experiences within the wider context of previous research and theory. Adopting a biographical approach has facilitated a detailed and in-depth insight into the experiences of military spouses living alongside their UK serving partner during a mental health issue. As the first biographical study in the UK specific to this area, the study is able to bring new original contributions to knowledge. The study's overarching strengths and limitations are presented and, through critical reflection of the findings, several recommendations for future research, policy and practice have been generated. The chapter culminates by presenting the thesis' main conclusions and dissemination plans.

8 Appendices

8.1 Appendix 1: Scrutiny check of included studies

Qualitative studies: **Quality assessment using Kuper, Lingard and Levinson guidelines.**

Note. (1) VG: Very Good; G: Good; A: Acceptable; U: Unsure; (2) Inclusion in review: Studies were required to meet four of six guidelines and be ranked 'acceptable' or above.

Source	Data analysis method	Was it clear what the researcher did?	Was the sample appropriate?	Was the data collected appropriately?	Was the way the data was analysed appropriate?	Are the results transferable?	Was ethics considered?
Brown, V. A. (2015)	Thematic analysis	VG	G	VG	VG	G	VG
Buchanan, C., Kemppaninen, J., Smith, S., MacKain, S. & Wilson-Cox, C. (2011)	Thematic analysis	VG	VG	G	VG	G	G
Iniedu, A.O.E. (2010) [29]	Thematic analysis	VG	G	G	G	G	VG
Lyons, M. A. (1999)	Thematic analysis	G	G	VG	G	G	VG
Mansfield, A.J., Schaper, K.M., Yanagida, A.M. & Rosen, C.S. (2014)	Thematic analysis	G	VG	A	A	A	A
Sherman, M.D. Blevin, D. Kirchner, J Ridner, L & Jackson, T (2008)	Thematic analysis	G	G	VG	G	G	U
Temple, J. McInnes Miller, M. Banford Witting, A & Kim, A.B. (2017)	Thematic analysis	A	A	G	G	G	A

Verbosky, S.J. & Ryan, & D.A. (1988)	Thematic analysis	A	VG	A	A	A	U
Waddell, E Pulvirenti, M & Lawn, S (2016)	Thematic analysis	G	VG	G	VG	G	VG
Woods, J. N. (2010)	Thematic analysis	G	G	VG	VG	G	VG
Yambo, T.W. Johnson, M, E. Delaney, K. R. & York, J.A. (2016)	Thematic analysis	G	G	G	VG	G	VG
Thandi, G., Oram, S., Verey, A., Greenberg, N., & Fear, N.T. (2016)	Thematic analysis	G	VG	G	VG	G	VG
Murphy, D., Palmer, E., Hill. K., Ashwick, R. & Busuttil, W. (2018)	Thematic analysis	G	G	VG	VG	G	VG
Waddell, E., Lawn, S., Roberts, L., Henderson. J., Venning, A., Redpath, P. & Sharp-Godwin, T. (2020)	Thematic analysis	G	G	VG	VG	G	VG
Brickell, T.A., Cotner, B.A., French, L.M., Carlozzi, N.E., O'Connor, D.R., Nakase-Richardson, R. & Lange, R.T. (2021)	Thematic analysis	VG	VG	G	VG	G	VG
Johnstone H. & Cogan, N. (2021)	Thematic analysis	G	A	G	VG	A	VG

Quantitative studies: Quality Assessment Tool developed by Thomas et al.

Note: Each section has individual component rating which is cross referenced against followed by an overall rating as Strong (1), Moderate (2) Weak (3)

	Allen et al	Beckman et al	Daniels	Campbell & Renshaw	Jordan et al	Manguno-Mire et al	Renshaw & Caska	Riggs et al	Sautter et al	Calhoun et al	Martinez
1. Selection bias											
A Are the individuals selected to participate in the study likely to be representative of the target population?	1	1	1	1	1	1	1	1	1	1	1
B What percentage of selected individuals agreed to participate?	1	N/A	3	3	1	3	5	N/A	1	5	2
Section rating	**1**	**2**	**3**	**3**	**1**	**3**	**2**	**2**	**1**	**2**	**2**
2. Study design											
D Was the study described as randomized? If NO, go to section 3.	4	5	7	7	4	7	3	8	8	8	4
Section rating	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**3**	**3**	**2**	**2**
3. Confounders											
E Were there important differences between groups prior to the intervention?	1	N/A	N/A	N/A	1	N/A	2	1	N/A	1	N/A
F If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?	1	N/A	N/A	N/A	3	N/A	N/A	1	N/A	1	N/A
Section rating	**1**	**-**	**-**	**-**	**3**	**-**	**2**	**1**	**-**	**1**	**-**
4. Blinding											
G Was (were) the outcome assessor(s)	N/A	1	N/A	N/A	N/A	N/A	N/A	1	N/A	1	N/A

aware of the intervention or exposure status of participants? **H** Were the study participants aware of the research question?	N/A	3	N/A	N/A	N/A	N/A	N/A	1	N/A	3	N/A
Section rating	**-**	**3**	**-**	**-**	**-**	**-**	**-**	**1**	**-**	**3**	**-**
5. Data collection methods **I** Were data collection tools shown to be valid?	1	1	1	1	1	1	1	1	1	1	1
J Were data collection tools shown to be reliable?	1	1	1	1	1	1	1	1	1	1	1
Section rating	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
6. Withdrawals and drop-outs **K** Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?	3	3	1	N/A	N/A	1	N/A	N/A	1	4	N/A
L Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).	4	4	1	N/A	N/A	4	N/A	N/A	1	1	N/A
Section rating	**3**	**3**	**1**	**-**	**-**	**3**		**-**	**1**	**2**	**-**
7. Analyses **M** Indicate the unit of analysis :community(1) organization/institution(2) practice/office(3) individual(4)	2	2	4	2	2	2	2	2	2	2	4
N Are the statistical methods appropriate for the study design**?**	1	1	1	1	1	1	1	1	1	1	1
Section rating	**1**	**1**	**2**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**2**
Overall rating : Strong (S) Moderate (M) Weak (W)	**2 (M)**	**2 (M)**	**2 (M)**	**2 (M)**	**2 (M)**	**3 (W)**	**1 (S)**	**2 (M)**	**2 (M)**	**2 (M)**	**2 (M)**

8.2 Appendix 2: Themes generated from the chosen papers

Paper	**Theme identified**				
	Theme 1	**Theme 2**	**Theme 3**	**Theme 4**	**Theme 5**
1	X	X			
2	X		X		
3	X		X	X	
4				X	X
5		X			
6	X				
7		X	X		
8		X	X		
9	X	X	X		
10	X		X		
11	X	X		X	
12		X			
13		X			
14	X				
15	X	X		X	X
16	X		X	X	X
17		X	X		
18	X	X	X	X	
19		X	X		
20	X	X	X		X
21	X		X		
22	X	X	X		X
23		X	X		
24			X		X
25	X	X	X	X	
26	X	X	X	X	
27	X		X		X

8.3 Appendix 3: Northumbria University ethical approval notification

From: EthicsOnline@Northumbria <EthicsOnline@Northumbria>

Sent: 26 January 2018 03:30

To: emma.senior <emma2.senior@northumbria.ac.uk>

Subject: Research Ethics: Your submission has been approved

Dear emma.senior,
Submission Ref: 2879
Following independent peer review of the above proposal*, I am pleased to inform you that **APPROVAL** has been granted on the basis of this proposal and subject to continued compliance with the University policies on ethics, informed consent, and any other policies applicable to your individual research. You should also have current Disclosure & Barring Service (DBS) clearance if your research involves working with children and/or vulnerable adults.
* note: Staff Low Risk applications are auto-approved without independent peer review.
The University's Policies and Procedures are here
All researchers must also notify this office of the following:

- Any significant changes to the study design, by submitting an 'Ethics Amendment Form'
- Any incidents which have an adverse effect on participants, researchers or study outcomes, by submitting an 'Ethical incident Form'
- Any suspension or abandonment of the study.

Please check your approved proposal for any Approval Conditions upon which approval has been made.
Use this link to view the submission: View Submission
Research Ethics Home: Research Ethics Home
Please do not reply to this email. This is an unmonitored mailbox.

8.4 Appendix 4 – Participant information sheet

Northumbria
University
NEWCASTLE

Faculty of Health & Life Sciences

To explore the experiences of military spouses living alongside their UK serving partner during a mental health issue.

Participant Information Sheet

You are being invited to take part in three separate interviews regarding your experiences whilst your partner was undergoing treatment for their mental health problem. Before you decide it is important for you to read this leaflet so you understand what is involved and what will happen to the information collected.

What is the Purpose of the Study?

Within England, it is estimated that 1 in 8 adults will experience a common mental disorder (CMD) at some point in their lives. It is widely accepted throughout the NHS that the inclusion of the main family member/carer in the treatment of a person with a mental health problem can aid recovery and provide vital support in managing the condition for both the client and their family. Within Department of Health (DOH) policies, the family member/carers are mentioned throughout; they refer to:

- Family member/carer's involvement,
- the requirement of being given written and verbal information regarding diagnosis & treatment, positive outcomes & recovery,
- support for family member/carers,
- the role of the teams and services involved,
- how to get help in a crisis.

Mental healthcare provision for UK serving personnel is provided in-house by Defence Medical Services (DMS); these services are aligned to and delivered following the same policies and guidance as the National Health Service (NHS). As DMS mirror that of the care provided by the NHS, it could be assumed that family members/carers would be included in the care during a mental health issue.

This research will seek to explore the experiences of military spouses living alongside their UK serving partner during a mental health issue.

Why have I been asked to take part in this study?

You are being invited to participate in this study because you are the partner of serving UK military personnel who have at some point had a mental health issue.

Do I have to take part in the study?

No, it is up to you to decide if you wish to take part. I will meet with you to discuss the study in more detail. You will also have an opportunity ask any questions you may have.

If you agree to take part, then I will ask you to sign a consent form to show that you have agreed to take part. You are free to withdraw from the study at any time, without giving a reason. Withdrawal will not affect you in any way and your decision to withdraw will not be shared with anyone.

What am I being asked to do?

You are being asked to participate in a three separate interviews, each lasting approximately 30-45 minutes. This may be at your own home or another agreed site local to you. The purpose of these interviews is to:

- share your life story as a partner of serving personnel who had at some point during their serving career experienced a mental health issue; namely, common mental health disorders (depression, anxiety), adjustment disorder, or post-traumatic stress disorder.

Are there any disadvantages to taking part?

I am aware that you may be identifiable due to the nature of the sample chosen, however your name will not be disclosed, and any data generated will be labelled with your unique identifier number. You may also experience the potential inconvenience of having to take part in the interviews which may last for up to 30-45 minutes. There may be times during the interviews when the discussion may be emotional or distressing. There will be an opportunity outside of the interview to discuss these situations and signpost you to the most appropriate services that will be able to provide support and guidance for you and your family.

What are the benefits of being involved?

Through sharing your views and experiences you can help inform future plans of support and care for those serving personnel and their families when receiving treatment for a mental health problem. There are no risks involved, however it is entirely up to you as to whether you choose to be involved

What if I change my mind about being involved?

You can withdraw from the interview or the research study at any time. Any data collected will be destroyed and not included in the study.

Confidentiality

Will my input be kept confidential and anonymous?

Yes. Although we ask you to sign to say you were given information about the study (informed consent) before agreeing to be involved, neither your name nor any personal details attributable to you will be included in any of the reports or publications resulting from this study. The data collected from you will be confidential. The only exception to this confidentiality rule would be if you were to tell us of an instance in which someone else (or yourself) had been harmed – in which case we would be legally bound to disclose this information to the police (for criminal matters), Safeguarding or professional regulators (in cases where this due to professional malpractice).

Collecting the data.

The data for this study will be collected using a Digital Dictaphone Recorder during the interview. Once the interview has ended the recording will be transcribed and a written record of our discussions will be created. You will have an opportunity to review the transcribed copy. The data will not contain your name or any personal details and any paper-based record will be securely stored.

Storage of the interview tapes, transcripts and other papers

The tape recorder will be transported from the interview venue to my locked office in a lockable briefcase. All data, the recordings and any paper based information will be kept in a locked cupboard at Northumbria University, in my locked office, until the research is completed. Once the study ends, the tapes will be wiped clear. The paper transcription of the interviews will be stored securely in a locked cupboard, in my locked office, at the University. All data will be stored in accordance with University guidelines and the Data Protection Act (1998). These documents will be anonymous and are marked by a unique identifier (allocated to you by me). Once the study is completed any paper information will be shredded.

The only individual who will have access to the tapes and papers is myself.

Any information which is produced as part of the dissemination activities associated with the project will not bear your name.

What will happen to the results of the study?

The results will form part of a report which will be disseminated by myself and will be made available to study participants, other practitioners and academics. The results will also be published in education and health care journals and within a PhD dissertation. You will never be identified in any publication although your words may be published exactly as you said them during the interview.

Who is funding and organising the study?

This research is funded and supported by Northumbria University through its programme of staff development and scholarly activity.

Who has reviewed this study?

The Faculty of Health and Life Sciences Research Ethics Committee at Northumbria University have reviewed and approved this study.

Where can I find further information about the research?

In the first instance please contact myself.

Emma Senior – Principal Investigator (0191) 215 6715

If you have any questions about this study, please contact

Dr Amanda Clarke PhD Supervisor (0191) 215 6610

Complaints

If you have concerns about any aspect of this study, please speak to either me, or my PhD Supervisor (details below).

Information disclosure

Emma Senior is a Registered Nurse and Health Visitor and is governed by the Nursing and Midwifery Council (NMC); I will inform you at the initial meeting of the NMC Code (2010), and also the NMC Raising and Escalating Concerns Regulations (2010).

Research Team

Principal Investigator	Emma Senior, Northumbria University
	Telephone (0191) 215 6715
	E-mail emma.senior@northumbria.ac.uk
PhD Supervisor	Dr Amanda Clarke, Northumbria University
	Telephone (0191) 215 6610
	E-mail amanda.clarke@northumbria.ac.uk

8.5 Appendix 5 – Debrief sheet

Participant code:

PARTICIPANT DEBRIEF

Northumbria University
NEWCASTLE

Name of Researcher: Emma Senior,
Name of Supervisor: Amanda Clarke

Thank you for your participation within my research entitled:
‘ To explore the experiences of military spouses living alongside their UK serving partner during a mental health issue.’

1. **What was the purpose of the project?**
   The purpose of the study was to explore the experiences of military spouses living alongside their UK serving partner during a mental health issue. Through the sharing of your views and experiences, they can help inform future plans of support and care for those serving personnel and their families when they receive treatment for a mental health issue.

2. **How will I find out about the results?**
   The results will form part of a report, which will be disseminated by myself and will be made available to you. I will share the transcripts of our interview with you in written format.

3. **If I change my mind and wish to withdraw the information I have provided, how do I do this?**
   You can withdraw from the interview or the research study at any time. Any data collected will be destroyed and not included in the study.

The data collected in this study may also be published in scientific journals or presented at conferences. Information and data gathered during this research study will only be available to the research team identified in the information sheet. Should the research be presented or published in any form, all data will be anonymous (i.e. your personal information or data will not be identifiable).

All information and data gathered during this research will be stored in line with the Data Protection Act and will be destroyed 12 months following the conclusion of the study. If the research is published in a scientific journal it may be kept for longer before being destroyed. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will your personal information or data be revealed. Insurance companies and employers will not be given any individual's personal information, nor any data provided by them, and nor will we allow access to the police, security services, social services, relatives or lawyers, unless forced to do so by the courts.

If you wish to receive feedback about the findings of this research study then please contact the researcher at emma.senior@northumbria.ac.uk or 0191 215 6715

This study and its protocol have received full ethical approval from Faculty of Health and Life Sciences Research Ethics Committee. If you require confirmation of this, or if you have any concerns or worries concerning this research, or if you wish to register a complaint, please contact the Chair of this Committee (Dr Nick Neave: nick.neave@northumbria.ac.uk), stating the title of the research project and the name of the researcher.

8.6 Appendix 6 – invitation letter

Faculty of Health and Life Sciences

Room H007

Coach Lane Campus

Newcastle upon Tyne NE7 7XA

Tel 0191 2156715

emma.senior@northumbria.ac.uk

Date:

INVITATION TO PARTICIPATE IN RESEARCH STUDY

Dear

The aim of this research is to explore the experiences of military spouses living alongside their UK serving partner during a mental health issue.

You are invited to participate in this study. Before you decide you need to understand why the research is being done and what it would involve from you.

The research is not directly funded by Northumbria University however is part of a PhD study.

You are being invited to participate in this study because you are the partner of serving UK military personnel who have at some point had a mental health issue.

Enclosed is an information sheet which details the research and what you will be required to do if you agree to take part. Please read this carefully. I will contact you via telephone or e-mail to find out if you are interested in taking part in this research. If you are, I will make arrangements to meet with you to provide further information and to answer any questions you may have.

You will then be offered a few days to consider whether you wish to be involved. If you do get involved all of the information collected from you will be held in the strictest confidence. In addition, you will be free to withdraw from the study at any time without this affecting you in any way.

Thank you for taking the time to consider being involved in this study

Yours faithfully,

Emma Senior. Principal Investigator / Lead Researcher

8.7 Appendix 7 – Consent form Interview 1

Northumbria University
NEWCASTLE

PARTICIPANT CONSENT FORM

Research Title: To explore the experiences of military spouses living alongside their UK serving partner during a mental health issue.

Researcher: Emma Senior.	**Yes (please tick)**	**No (please tick)**
I have read and understand the Information Sheet and have had the opportunity to ask questions which have been answered to my satisfaction.		
I understand that I do not have to take part. If I do take part I may withdraw at any time, without giving a reason.		
I agree to take part in the Interview**.** I understand that the discussion will be audio recorded, and in notes made by the researcher. I give permission to the researcher to have access to this information for analysis		
I understand that I have the right to withdraw from the interview and any contribution made will not be used.		
I understand that the information I have given in this study may be used in the future as part of further work on this subject.		
I understand that findings from the study will be anonymised and that my name and details will not appear in any printed documents**.**		
I would like to receive a summary of the results of the study		
I understand that data collected during the study may be looked at by individuals from authorities regulating research conduct (e.g. University ethics auditors). I give permission for these individuals to have access to the data.		
I know that my name and details will be kept for interview 1 of the study. I am happy to have these details retained for future contact.		
All of the information that you share will be kept confidential by the research team. The only exception to this rule would be if you were to tell us of an instance in which someone else (or yourself) had been harmed – in which case we would be legally bound to disclose this information to the police (for criminal matters), Safeguarding or professional regulators (in cases where this due to professional malpractice).		

Name of Participant **Date** **Signature**
Name of Researcher **Date** **Signature**

8.8 Appendix 8 – Support information document

Participant Information: support services

You may feel that the interview raises some questions or feelings that you may like to talk about further. The list below contains a range of organisations and support services which you or those close to you may find helpful.

Contact details for support organisations

Army Welfare Service (AWS)

AWS provide a comprehensive, professional and confidential welfare support service responsive to the needs of individuals and families. Personal Support Staff provide accessible, independent, confidential and professional specialist welfare services to soldiers and their families with any personal or family difficulty.

For all Personal Support enquiries and referrals please contact the Intake and Assessment Team on:
Helpline: 01904 882053 Available 24-hours a day, 365 days a year
Email: RC-AWS-IAT-0Mailbox@mod.uk
Website: http://www.army.mod.uk/welfare-support/23199.aspx

Royal Navy Royal Marine Welfare Service

RNRM Welfare offers advice, support (practical or emotional) and advocacy for Service Personnel. These services are also available to individuals, couples or families. On occasion these services are delivered in partnership with other agencies.

For information contact:
Tel: +44(0)2392 728777

Or if you prefer to use Social Media you can also post on our Facebook page, Tweet us @RNRMWelfare #RNRMW, or join the Royal Navy forum.
Website: https://www.royalnavy.mod.uk/welfare/welfare-teams

Royal Air Force Welfare Service

Personal Support & Social Work Service (PS&SWS) to the Royal Air Force is provided by SSAFA. SSAFA provide a Single Point of Contact facility which provides emotional and practical support for all service personnel and their families.

You can contact :
Tel: 03000 111 723 - Available 24-hours a day, 365 days a year
EMAIL: psswsRAF@ssafa.org.uk Our offices are also open Monday-Friday 08.30-17.00
Website: https://www.raf.mod.uk/community/mura-raf-community/assets/File/20170823-RAF%20Single%20POC%20Poster.pdf

Relate

Confidential counselling and advice for couples and families, including those dealing with problems or trauma. Relationship experts offer advice in person, over the phone or by email.

You can contact:
Tel: 0845 456 1310 Monday to Thursday 8.00am – 9.00pm. Friday 8.00am – 5.00pm, Saturday 9.00am – 5.00pm.
Email: relatedirect@relate.org.uk
Website: www.relate.org.uk
There are branches around the North East. Tel: 01325 461 500 for advice on the nearest.

Samaritans

Emotional support for anyone in need. They know a lot about what can help you through tough times.

They can help you explore your options, understand your problems better, or just be there to listen.

You can contact:
Helpline: 116 123 - Daily (24 hours)
Email: jo@samaritans.org
Website: www.samaritans.org
To locate your local branch contact details are on the Samaritans website:
http://www.samaritans.org/branches

Change, grow, live (CGL)

CGL works in partnership with service users to help them change their lives for the better and achieve positive and life-affirming goals. Areas of expertise include:

- Substance misuse
- Children and young people's services
- Family services
- Accommodation & homelessness
- Clinical services
- Criminal justice

Contact is via the links provided on the website: https://www.changegrowlive.org/get-help/find-a-service

National Domestic Violence Helpline

The Freephone 24 Hour National Domestic Violence Helpline, run in partnership between Women's Aid and Refuge, is a national service for women experiencing domestic violence, their family, friends, colleagues and others calling on their behalf.

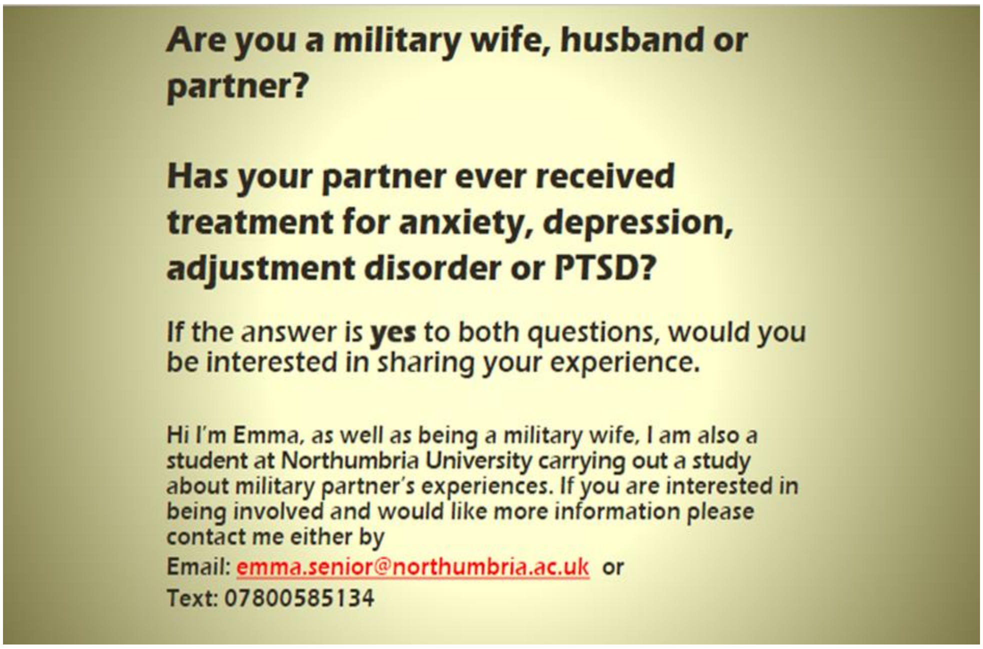
To contact:
Tel: 0808 2000 247 Daily (24 hours)
Website: http://www.nationaldomesticviolencehelpline.org.uk/

Combat PTSD Angels

They offer friendly, confidential advice and support to those caring for UK veterans suffering from combat related PTSD. They offer support that can only be given by someone who has been through the same situation.

To contact:
Tel: 07979737950
Email: admin@combatptsdangels.co.uk
Website: http://combatptsdangels.co.uk/

8.9 Appendix 9 Recruitment posters and postcards



Are you a military wife, husband or partner?

Has your partner ever received treatment for anxiety, depression, adjustment disorder or PTSD?

If the answer is **yes** to both questions, would you be interested in sharing your experience.

Hi I'm Emma, as well as being a military wife, I am also a student at Northumbria University carrying out a study about military partner's experiences. If you are interested in being involved and would like more information please contact me either by

Email: emma.senior@northumbria.ac.uk or

Text: 07800585134

Are you a military wife, husband or partner?

Has your partner ever received treatment for anxiety, depression, adjustment disorder or PTSD?

If the answer is **yes** to both questions, would you be interested in sharing your experience.

Hi I'm Emma, as well as being a military wife, I am also a student at Northumbria University carrying out a study about military partner's experiences. If you are interested in being involved and would like more information please contact me either by Email: emma.senior@northumbria.ac.uk or

Text: 07800585134

8.10 Appendix 10: Amy Families Federation article

Working on your wellbeing

Army life can seem like an endurance test, particularly if you're new to it, so looking after your mental health is key. *Jill Misson* reports...

"WELL, you must have known what you were letting yourself in for when you married a soldier."

How many times have you heard that old chestnut? People have no idea what a culture shock it can be.

Army spouse Katie Mills recalled: "I was not prepared, and my mind was in turmoil. I didn't understand the lingo and had so many questions. The worst part is when your partner is away and you're staring at the blank walls of your new home trying to comprehend the world you're now part of."

WHEN WORRIES ESCALATE

Practical information is often easy to access by asking a neighbour, reading a hand-out or popping into the HIVE.

Other concerns are more personal, as AFF's Wiltshire Co-ordinator Carol Morris explained: "There's a sense of the unknown. Will I make new friends? Can we cope on one wage until I find a job?

"Some find the lifestyle claustrophobic and feel that everyone on the patch knows their business."

For 18-year-old Anastasia Cuthbertson, the first posting a long way from home has been hard. She said: "I gave up my education so we could be together as a family. It has been character-building, but I can't finish my studies because of the cost of childcare."

Anastasia relies on her local friends for guidance, which is very common according to Carol: "The majority of young spouses will ask someone they met at the school gate or at a coffee morning and some may post on social media.

"Sometimes they don't have the confidence to approach their welfare team or don't want to be seen as a welfare case."

SEEK HELP

The charity Home-Start has a long record of working with

Forces families in the UK, Germany and Cyprus. A trained volunteer can visit your home for two hours a week.

Shelagh Chapman said: "Loneliness, physical and mental health issues, addictions and abuse can impact parents' capacity to provide support for their children. For Army families these issues are further exacerbated by the additional pressures of enforced separation."

As a unit welfare officer, Capt Stuart O'Hagan recognises the isolation some spouses experience and the need to create strong communities where neighbours help each other out. He encourages families to come forward: "Many are reluctant to seek help until it may be too late or require more effort to resolve an issue that has escalated."

When Ellie Wolf discovered her father only had days to live, her patch friends rallied to look after her cat while she was away.

She said: "It took a massive burden off my shoulders at a stressful time and it's this sort of care that you don't always get on civvy street.

"The Army were amazing at getting my husband back from the Middle East within 24-hours so that I had him by my side."

LOOKING AFTER YOU

To maintain your own wellbeing, AFF Health Specialist Karen Ross advised: "Keep yourself physically well, eat well and rest well. Keep in touch with family and friends using Skype or FaceTime and if you're feeling down speak to someone you trust. If low mood persists it is important to see a medical professional."

Spouses and soldiers can self-refer to The Warrior Programme, a free coaching course that empowers participants by increasing their emotional resilience and self-esteem.

Joining a sports club or taking up a new hobby can also boost confidence. Vicki Booth suffered with anxiety and depression until she plucked up the courage to go along to Military Wives Choir in Dishforth. She said: "It saved my mental health and has given me my life back. I am no longer just a wife and mother. My choir friends are like sisters."

WORRIED ABOUT WELLBEING

Researchers on the Helping Armed Forces Loved Ones (HALO) study are inviting relatives who are worried about the mental health of a veteran or soldier to complete a survey to help them develop skills training for Forces families.

Co-ordinator Marc Archer said: "While there is still stigma around mental health, this isn't necessarily the reason why people don't seek help. It's not always easy to know if the behaviours we worry about are indicators of a disorder that needs outside help."

When Emma Senior's husband Jase returned from Afghanistan, he avoided socialising and was restless at night. She said: "As I'm a nurse I tried to help him, thinking together we could work through it, but I soon realised I couldn't do it on my own. It was lonely, and I felt helpless."


Cared for by the community: Ellie Wolf and husband Anton

Emma convinced Jase to seek medical help and, after diagnosis and treatment, he continues to serve in the Army. She has started a project collecting partners' experiences of living with a serving person with a mental health illness – emma.senior@northumbria.ac.uk

RAISING AWARENESS

Recognising the signs that someone needs support is part of the Mental Health First Aid course that Carol Morris and AFF colleagues completed.

She said: "A conversation with a spouse may be about a dripping tap in their SFA, but once they start opening up, I'm able to distinguish those that need help and then I can signpost them."

In future all serving personnel will undertake mental health awareness training. Senior health adviser Maj Pauline Murray-Knight said: "We need to reduce stigma surrounding mental ill health whilst embedding the concept of mental fitness for all.

"We can all make a difference by listening and responding in a supportive and non-judgemental manner."

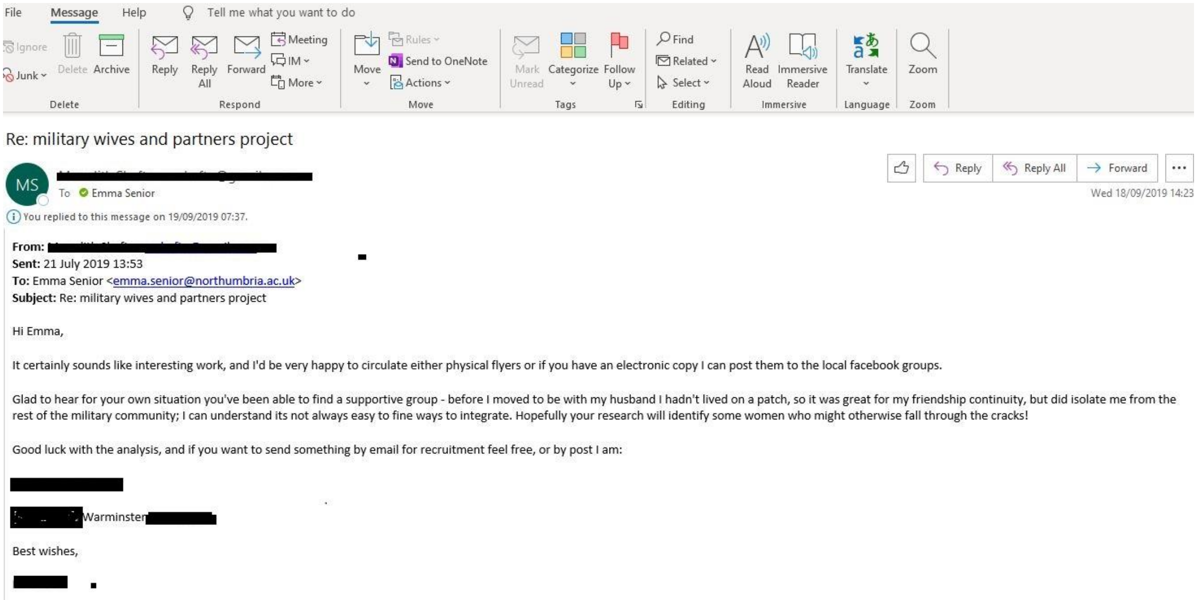
Now accustomed to Army life, Katie Mills advises others struggling to cope: "It's a glorious community and I am grateful for the support I received so don't be afraid to ask for help.

"There will always be someone there to lend a hand until you can stand alone."

SOURCES OF HELP

- warriorprogramme.org.uk
- **home-start.org.uk**
- HALO: Marc Archer at halo@kcl.ac.uk or kings.onlinesurveys.ac.uk/halo-survey-2019
- **For Army welfare information and to find your local HIVE, search army.mod.uk**
- militarywiveschoirs.org
- **AWS: call 01904 882053 or 882054 or email RC-AWS-IAT-0mailbox@mod.gov.uk**
- bigwhitewall.com
- **theripplepond.org**
- helpforheroes.org.uk
- **maternalmentalhealthalliance.org**
- counselling-directory.org.uk
- **Forcesline: 0800 731 4880**
- If you or a family member is experiencing mental health or emotional wellbeing issues, contact AFF Health & Additional Needs Specialist Karen Ross by email at additionalneeds@aff.org.uk

8.11 Appendix 11: Email received to disseminate study promotion materials. (Name and email address blocked to protect individual)



Re: military wives and partners project

[redacted]
To Emma Senior
Wed 18/09/2019 14:23

You replied to this message on 19/09/2019 07:37.

From: [redacted]
Sent: 21 July 2019 13:53
To: Emma Senior <emma.senior@northumbria.ac.uk>
Subject: Re: military wives and partners project

Hi Emma,

It certainly sounds like interesting work, and I'd be very happy to circulate either physical flyers or if you have an electronic copy I can post them to the local facebook groups.

Glad to hear for your own situation you've been able to find a supportive group - before I moved to be with my husband I hadn't lived on a patch, so it was great for my friendship continuity, but did isolate me from the rest of the military community; I can understand its not always easy to fine ways to integrate. Hopefully your research will identify some women who might otherwise fall through the cracks!

Good luck with the analysis, and if you want to send something by email for recruitment feel free, or by post I am:

[redacted]

[redacted] Warminster [redacted]

Best wishes,

[redacted]

8.12 Appendix 12: Example of pen portrait

Pen portrait - Participant 001

Christina married to Daniel– Army

Met in school/college, had same group of friends. Daniel always interested in army and Christina nursing. Christina went to army recruitment first to join as a nurse, Daniel went after to join army- Christina was the incentive to go join. Wasn't the right time for Christina to join, moved into a flat, working for SRH as a HCA. For Paul, when the army began to be a reality – anxiety increased for Paul. With Christina 's support Daniel decided it wasn't the right time to join and would delay starting and to may be try working in civilian world first. Daniel worked putting signs up. Daniel moved into Christina 's flat and things were ok. Three years later Daniel was contacted by the army to join – at this point Daniel felt ready. On joining Daniel found it difficult being away from Christina, he struggled, crying and anxious however there was no clear diagnosis at this point. During phase 1 Daniel asked Christina to get married. He passed out on the Friday, got married on the Saturday and then moved down south for phase two of his training on the Monday. Christina went with him, first year of marriage was hard for Christina, Daniel wasn't keen on socialising which made it difficult for Christina when meeting other military wives and Christina missed home. Christina moved back to the north two months before Daniel phase two had finished.

Daniel was then posted back up north to Catterick where Christina and Daniel had a quarter. Daniel was then deployed to Afghanistan; he enjoyed the tour no major incidents whilst on tour. Christina settled into life at Catterick meeting other military wives, helping others with shopping etc. Christina was a bit of anomaly as she worked full time and had no children which was very different to most of the military wives on the estate. Met lots of friends while Daniel was away and had always explained to them that Daniel was not keen on socialising didn't want to become involved with others. Christina received and was good support whilst husbands were on tour.

On returning form tour, the adjustment was difficult as Christina had developed a whole new network of friends. Christina applied for her nursing training and was successful, as she was due to start Daniel was posted down south for six months. As Christina was starting her degree, she decided to stay up north, approx. 300 miles away. When Daniel went away, anxiety worsened to the point where he was unable to cope being away – unable to manage completing the day-to-day tasks required of him. On Christina 's first day of university, Daniel was so anxious that a lot of her time that day was focused on supporting Daniel over the phone. Christina encouraged Daniel to attend the med centre to speak to someone as she felt there was nothing else, she could do. Daniel was diagnosed with anxiety and received a course of counselling. Daniel attended the counselling but did not speak of it – no contact was made with Christina from the military mental health team. In some respects, at times Christina felt a bit like a surrogate mother, she did research into depression and anxiety to try and support Paul. Christina found some study relating depression to a big black dog sitting on your chest which grew as times – on discussing this over the phone with Paul, he really related to the analogy.

Daniel still continues with depression and anxiety with medication and further counselling being prescribed, of which he has chosen not to engage with. No-one at work knows that Daniel has these episodes, and he is very good at having 'his game face' on at work. Now that Christina and Daniel have their own home, DIY and jobs around home also exacerbate his condition. Since living apart and Christina completing her degree, Daniel has had to learn to be a little more independent and not rely on Christina. At times it is hard for Christina, and she wonders if this is how it's going to be for the rest of their time together, but she loves him and that why she carries on. For Christina, she never just wanted to be Paul's wife and by doing her nursing degree has found a little bit of her again.

8.13 Appendix 13: Example transcript illustrating '*story*' analysis

Participant 001 transcript

Beginning emergence of CMHD This is me

Photo's brought were a couple one following passing out parade and one when passed phase 1 training.

E: tell me your story

C: from the beginning erm erm,

E: yeh

C: erm, well we met at school erm so we were 17 in the same group of friends in sixth form, just sort of hung around together for about 18 months before we started dating, erm, and we were dating for about 3 or 4 month and it was always known with D, throughout all school he never applied himself with any of his grades cos I'm going in the army, as if he didn't need them. Erm and it was funny cos I had looked into it first cos I always wanted to do nursing, and I thought in a ways I'm gonna look into a military career, so I actually went to XXXXXX, to the careers recruitment offices on me own, and just walked in, was like look, I'm really interested in nursing would like to think about doing it in the army and got sort of the ball rolling, and he was just I think he got a little bit jealous and thought its me that wants to be in the army. So he then went after me, I think I sought of got him the ball rolling. And then with three or four months he got a post with a position to sign up when he was 18 and he absolutely I don't want to swear but he absolutely crapped his pants, and I was like if you're not ready, you're not ready and I said at that point, that erm family life with me, I got a job at Sunderland Royal hospital cos I had to move out of home and I had to get a flat, had to financially support myself so that was on hold for me, nursing was on hold. And I just said look if you're not ready, don't do it, go get a normal job, get a job in civvy life and see what it's like to be an adult. And he said really and I said yeh, no-one's gonna think any less of you, so that what he did, he declined the offer and went and got a job for a company, signs company going out fitting signs, going out in the vans and just, and D's a very, he's an engineer at heart and he's very hands on tactile, I've actually got a photograph where he's smiling stress free cos he is tinkering with a little bit of equipment. Erm and erm three years later about by this point we'd moved in the flat together, quite established as a couple, and he's gets another phone call, there's another position for you to sign up, would are you ready and he was like oh my god like and at 21 well like 20 I went are you ready and he went yeh yeh I think I am, so that was the Christmas and then he got his place to go to basic training erm the following May and erm that was when all the anxiety and everything started, he literally cried, at this point we were just a young couple not really that serious, cried every day on the phone absolutely sobbed that he wanted to come home, he couldn't cope without us, it wasn't being, he wasn't homesick, he was C sick. Erm and that was when he said looka, I think we are gonna have to get married, cos the lads are saying you can't come anywhere with us if you aren't my wife, you don't matter unless you are my wife, erm so I was like right ok then, I was like yeh whatever and then that was the whirlwind, basic training for three months, erm, he passed out on the Friday and we got married on the Saturday and then he went down to his second phase for a year on the Monday. So it was a total whirlwind. Erm he went and then and I think I don't know if that helped me being with him or whether that sort of I don't know fed an illness that needed something else. I don't know if I helped or not, so then we spent a year together in XXXXXX when he did his first phase, we were a newly married couple and it was really hard (pause) but erm, hard for both of us because obviously he was something new, learning, scared, I was away from my family, young girl, working a care home doing agency, and it put a massive strain the first year of marriage, was really hard but it got to he had another two months left and I was like I can't do anymore, I didn't leave him but I was like I've got to go home, so I packed up and went home two month early and left him down there and then he got a posting in XXXXXX, and I went right, let's start again and we moved to XXXXXX He was there two years in a new post doing really well and really good getting good reports and then Afghan come up, or no it was only a year sorry. Within that year, they said we are going to Afghan next year and are you happy to go, he said yep, yep. Erm, there was no like nothing no incidents happened when he was out there, nothing he was really lucky he didn't have any traumatic experiences, he looks back and he says it was the best time of his career, erm hes really lucky erm and at present he's obviously having an alright time over in Iraq. Erm the thing with D is though, he's very much a yes man, he's good at his job, do anything to help and erm, but he has always, always, always suffered and its just got worse and worse and worse with stress and anxiety and it is horrific to the point that he gets to the point where he gets, he's been seen, had ECG's cos he gets really bad chest pain, he gets a tightening in his throat, erm, and that really presented itself to the point where we had to seek advice was, he done afghan in 2012 and come back, had the typical really, nothing was diagnosed but when they come back and settle down period, really, E: yeh

C: him being,

E: its that adjustment isn't it

C: argh it was unreal again and that was another time that I thought I don't know if I can do it, but you kinda just got to be there for them. Erm but it just put a huge strain on the marriage.

E: so what were you like in that time then, what was it like from your point of view

C: erm, I had spent, so D likes to keep me with me, whenever we go anywhere, he's not very sociable, everyone finds it bizarre cos he doesn't drink really, he does now, he's suddenly found whiskey and rum. (smiles) but he has never ever, doesn't go out partying, he's never gone out with the lads drinking, he's very, when you think of a soldier he's literally the opposite erm, obviously its relatable with some men erm so but im quite out not outgoing but I'm bubbly I'm dead chatty and I'll talk to anybody and I love to socialise even if it is just for a coffee, (arms crossed) whereas P is like no no it's just me and you in the house, so we'll go camping we'll just do quiet things, so when we travelled all the time and he promised us all this time cos I was really lonely and everywhere we had gone he promised us that we would meet people, army wives you'll get friends but it never happened cos every time I started to meet somebody I would say 'oh they've said lets go round for tea' and he's like no, no I don't want to go, I don't want to socialise with someone from a different unit or a high rank and I was like D it doesn't matter and I tried so hard, and then while he was in afghan, obviously the neighbours rallied up, nearly all the neighbours, even though they weren't all in the same unit, it was XXXXXX so a lot of the units were away at the same time. So I really got this great bunch of girls who I am still in contact with now, really developed this bond and when he come back for his R&R we had a meal together and I was so nervous thinking hes not going to get on, made him out to be this monster, he's not very sociable, he might like just walk away if he doesn't wanna be there, erm and he was actually really good, but it really, it, when he come back, he really struggled with the fact that I had friends and he didn't, and I had met their husbands because their R&R's were different so I got on really well with their husbands so that was another issue. Erm so from my point of view was a bit like, I'm loving the army life but he isn't which was hard. Erm it was, it was I worked and obviously I worked shifts and as a carer I often worked weekends, 12 hours shifts whatever, he would always go home to obviously XXXXXX and XXXXXX is not far, and I would stay but during the week, when you're at work and I've got a day off I stay in our home, he was never like happy and that always, that was post afghan. Erm and then we just sorted plodded on after that, nothing again was diagnosed, there was nothing really presented itself where there was an issue and then he, his four year posting came up his first four year posting erm another posting in a unit that he always said he didn't want, it was XXXXX, and he had said just in XXXXXX erm cos his wife was doing her nurse training about to start her nurse training erm and I said look you got what you wanted you are in XXXXX, I'm really sorry but sadly he did, he was on there for erm I think a month and then he called on to his class 1 course which is 6 months back down in XXXXXX and I started my nurse training on Monday 24th March and he left on Sunday 23rd to go 6 months, so basically it was like a case of, and as he went down there, I've actually still got messages on my laptop, that's when it really started, it was cos we were separated again, whereas afghan we had no choice, this time he was in the country and it's like a separation anxiety thing, erm and I had my phone, my first day at uni, I didn't really speak to anyone cos I was on the phone to him. He was going to the Doctors erm he was like I can't cope, I need to get out, he was actually getting to the point where he was thinking of things where he didn't want to hurt himself but to actually it was a case of saying I'll just crash my motorbike and hurt myself enough I won't have to go to work and I was like they're not good thoughts erm and that was when that's when the real anxiety, that's when he actually, at this point no-one in the army knew until now, until then, so we have spent the past three years like it up and down, cos we have actually not lived together cos he then promoted straight after his class 1 and went to Scotland (long sigh and a little teary) so

E: oh

C: so that its in a nutshell, he's in a big anxiety ball that he gets really stressed but he's totally got a game face at work, no-one knows the problem. But he comes home and it's just like waaah.

E: so from your point of view how do you feel when he's like that

C: erm (pause) I feel like childlike, like motherly, just want to help him, it heart-breaking to see him like that but then I just keep saying is the job worth it but now he stresses have transferred because we have bought a house, when he thinks about doing jobs and that around the house and he gets himself really chewed up, I just I just, feel a bit helpless sometimes, I don't know how to help him erm but he is very good at erm that he can be talked down and then he'll go I just needed a Z talk erm but he erm eeee I'm gonna get myself upset its exhausting, ee I think this is quite emotional isn't it erm, it is exhausting (eyes begin to fill up, reaches for tissue in bag) there will be time where I have thought like ee do I really want to do this for the rest of my life, is this what the marriage is like because I don't know if its relatable to yourself, but P's very much always D's always been my number one and I'm always giving me 100% but he's never gave that back cos he's job, I've always accepted that, I've always have always will. Well I'm never first but I get that cos its fine it's not his choice but even when I could be his first, I never really am and it's hard to have that it's almost like an unconditional/non-conditional relationship where I literally would bend over backwards for him but he can't and then because he can't he's got used to that I can't, I can't, and just doesn't (tearful) erm my life always revolves around his and this three years is actually done us good cos he realises that actually the degree comes first and I can't take holidays outside of the time and its done us good. (reaches for tissue)

E: Yeh

C: erm (pause) but yeh that's it in a nutshell its erm, its hard, but you love them don't ya

E: Yeh you do

C: you sacrifice a lot but then you gain a lot, the people I've met the network of the people I've got across the country is unreal, I'm really really like I would never change that. (Tearful)

E: that's lovely, it's up to you whether you want to talk a bit more or whether you want to leave it there, I'm quite happy to do either, if you want to meet next week or you want to talk about you now it's entirely up to you

C: I really don't mind

E: it really is up to you, I don't want you getting mega stressed

C: oh no I'm not stressed, no honestly, I'm fine and just still emotional because of the end of degree and that

E: I know it's been a big thing for you you know going through all of this, I think the things your saying certainly from what I have read and everything is exactly what you are saying

C: so it's like textbook

E: well there is no textbook about it that's why im doing what I'm doing but the the similarities are just like you know unbelievable really, that they make me get a bit goose pimply and a bit kind of like

C: it's crazy isn't it how relatable things are and that you know your lives are completely all different and your all completely different people erm, I don't know if it's the. D's always had tendencies of this and the army has totally exacerbated it, the army life – the hurry up and wait, the life not everything being on hold and he describes this feeling all the time of being trapped, he's trapped, he can't his life's not in his control which er go my life's not on my control erm but yeh, then the married to it they love it and then I say to him you know, if you really want to get out you would and he has toyed with it the past three years but I keep saying you only toy with it cos I'm not with you, once we are travelling around together again, living together that you are fine

E: so did he seek treatment then

C: yeh and the threw it all down the pan

E: so how did that come about, what made him go

C: I think basically he had some sort of panic episode when he was down south, cos he left on the Sunday and it was horrendous and he didn't want to go. I said don't go, go see somebody, say you want to sign off, say you need help you you, I said emotionally you are unstable erm it but he still went, it was just horrendous, I didn't I wasn't even worried on my first day of uni cos I was to busy thinking about him and then first day at uni he was on the phone all day and he had got up that morning and hadn't gone on parade and that D's a very he's literally never been disciplined in his life he is such a good boy basically and for him to do that I was like whoa really something is not right – so he went to the med centre and just said look I need to see somebody erm and I don't know, he's quite closed he won't he won't talk about much but I know he had a chat with somebody and they set up some counselling sessions erm, they suggested that he just cracked on with the troops and did what he was meant to do because rather than like sitting in his room erm so he cracked on that week. He had a few counselling sessions which I think went over the six month period and attended those erm and then that sort of fizzled out and he didn't have any more following, he was offered medication which he took home but didn't take, he declined erm and then so that was 2015 and then this time last year so yeh 2017 last year erm he had chest pains got to the point where I was like you need to go seek help for that erm I says you need to go back and do counselling again erm so the, I felt like what he was doing with the counselling I don't know whether it was because I was so preoccupied here with all and being 300 miles away or whether it helped a bit and having that separation from me taught him to be independent because that's what I always used to say to him, talk to your friends, talk to your family, he used to say no I only want to talk to you and I say yeh but I am such a biased opinion erm and as much as I want to help you maybe I'm not doing you any good so I don't know whether during that six month period when he was having these sessions erm I don't know if that cos hes seemed to be good for a bit after that erm and then so 2017 was about this time 2017 the chest pains were really bad and the tightening in his throat he had complained bout it for a year but it was just touch and go were this time it was every day, every time he thought of something stressful, I was like please just go get it seen to so that when he went again and I am almost positive they offered him counselling again and he declined it this time. He was given omeprazole but for I know (giggle) I was like that's hilarious, I said you might just be getting an acidy, I said he might be getting a acidy stomach cos you're stressed but I know that's like an old wives tale erm but yeh and he's not been seeking treatment since then erm in a nutshell

E: so what about you in all that treatment

C: erm really hard cos I've been miles away every time and its been me gobbing on over the phone saying go see someone right you need to do it and he would come again and I would be like right I'm just gonna take you up to A&E cos I know for a fact you're not having any actual chest pains but just for you to get the mental health you need and I think I think all along I knew it was, I've known it's not physical erm but it's an on-going thing, I think he is always gonna have it and I think he needs the regular counselling but I think men are just like, it's a realisation thing as well, I remember once I'd seen this thing on the internet and I don't know if you might of heard of it, it's like depression depicted as a black dog, the big black dog sat on your chest and it gets bigger and bigger (tearful) eey I'm getting upset again, and I remember he I showed him this and he was away and I sent him the link and said read this and because its interesting reading and he read it I remember he was like a child ringing back and saying oh my god that's so me, I have a black dog that sits on my chest all the time, he was so child like the way he was talking but he doesn't have something to actually acknowledge that he had, got depression and that he gets anxiety cos I think he has never, even though he's been told this is what you've got I really just think he pretends he hasn't. (sigh) I think it's the job, I think

E: I think it's a lot of things in terms of it's a lot for them to handle and a lot for us to handle, you know it is a different world that no-one really gets unless you're living it

C: totally Completely

E: its quite difficult from every aspect I think that's you know

C: yeh, I think I might be wrong but from the men I have met and the women I think some people are a bit more pre because of the early experiences the post pre army experiences and how they are gonna deal with it, cos the people they have around them erm I think P as much as it is a textbook normal upbringing, his parents divorced when he was young, well when he was a teenager erm I don't know, I think we met at the time when his parents had just divorced and then I think he just wasn't really loved and I know it's being petty to go back and dramatic saying all that but that's where I have always been like a mum like I have always mothered him and that's what he has needed but then obviously it hasn't done him well to go be an independent man (laugh)

C: you sort of surround yourself with people don't you, I've always found that wherever I've gone I've always felt really lucky, I've like immersed myself in people that can get you through, distract you erm If there nothing to with army, not that it doesn't help but there's something there that nobody quite gets

E: you are right, I found it hard driving home from here cos it's such a long way and being away from a phone which was mental really but you know when you just go like

C: it's the knocks at the door as well isn't it it's when a car pulls up and you're looking out the window with going home is there gonna be a car waiting there

E: I used to wake up in the night thinking people where knocking on my door, run downstairs and there would be nobody there, it's just crazy isn't it.

C: since afghan I don't watch news, I've started again after Afghanistan watching it and then erm I so that why I got like I'm saying like the nursing times on my emails so I'm like I'm still getting the news that's relevant to me but no I've deleted like the BBC app.

E: You can just limit it to health, I have health and technology so you don't have to get

C: the normal stuff

E: but yeh I know what it's so similar like which is nice in a way that there is similarities that you do you know I think what I felt is that actually when I felt so alone but actually there is lots of other people going through the same thing but at the time you just think its you

C: Yeh

E: I think that's just you know one of the things

C: you get absorbed, you don't mean too, I try now to move away from all of the army life, I try so hard not to talk, not to talk about it but I think the girls at uni kinda get it, but at the same time I feel like I've got to say you like I don't just ignore people when P's home but you've gotta understand I think it's the army people get that, family get that but other people won't and they think like you're using them but I would never do that

E: yeh you're right, I think if you explain that, its only like someone working on the rigs they go off for a month and then be at home

C: you want to spend time with them. One of the biggest things for me what was a barrier was not having children really which I know was really big stereotype but when you've got mums who have got, going to the classes cos they do put things on and its really good but I once I got to know people I then attended without a child, it was always a bit odd but I didn't mind I just borrowed somebody else's, I was a bit of an anomaly on the street, to be somebody that was working, some of the boys went to afghan and when the snow came I was like the man really I was the one getting the shopping in them, rallying around made dinners yeh.

E: the life of an army wife isn't it.

C: yeh, I don't feel like one now

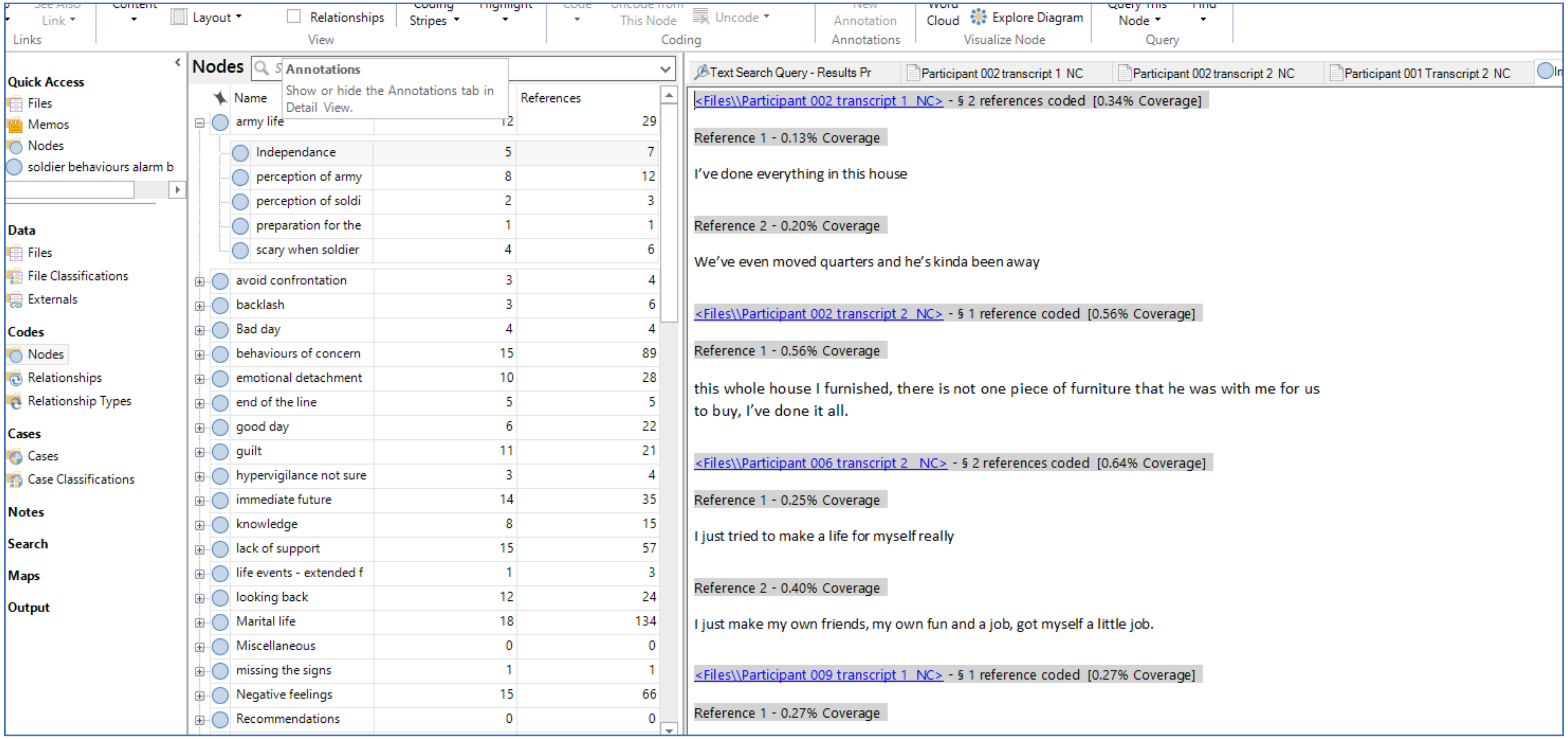
E: i think it's good that you've got your career now, I feel I'm proud to be an army wife but equally I'm proud to have my own career

C: you are established at who you are, I used to say that all the time I'm not just gonna be D's wife cos even though like (tearful) eey I'm getting upset here, I did graft, I really did, it like I did jobs everywhere we went and P used to laugh cos eey one day I might not actually get the job cos every job I went for I got, and I always used to think eey I'm not gonna get it, C you are, you always get them and I know but there is going to be a day when I’m not gonna get the job erm and yeh I’ve always like sort of shocked myself but I’m proud, I’ve always worked at least two jobs just work as many hours as I could just to sustain D’s lifestyle really cos I’m not a fashion person, I never buy clothes, we don’t really go on that many holidays but for D, I always feel like he needs his things cos he’s got a hard life with the army so I say yes get your motorbike, get your sporty car get anything you want, so then I’m always like I know it sound cliché but I’m always like cleaning the house, work hard to support that. We talked about the nursing for a while and when I said I was gonna do it I’ve totally changed over these last three years, I’m still a nice person, I’ve just been ordering him a Garmin watch and he’s buying this that and the other (laugh) and really try hard but like I’m going on holiday on Saturday with the Nicola and that and I would never do that, just for four nights, I’m me yep and I feel like I was before the army and I sort of lost that and yeh.

E: you found a little bit of you

C: yeh but then I love D more for it if that makes sense, I feel like I think he respects me more now yeh which hopefully will help his mental health.

8.14 Appendix 14: Examples '*category – content'* analysis



Name		References
army life	12	29
Independance	5	7
perception of army	8	12
perception of soldi	2	3
preparation for the	1	1
scary when soldier	4	6
avoid confrontation	3	4
backlash	3	6
Bad day	4	4
behaviours of concern	15	89
emotional detachment	10	28
end of the line	5	5
good day	6	22
guilt	11	21
hypervigilance not sure	3	4
immediate future	14	35
knowledge	8	15
lack of support	15	57
life events - extended f	1	3
looking back	12	24
Marital life	18	134
Miscellaneous	0	0
missing the signs	1	1
Negative feelings	15	66
Recommendations	0	0

<Files\\Participant 002 transcript 1 NC> - § 2 references coded [0.34% Coverage]

Reference 1 - 0.13% Coverage

I've done everything in this house

Reference 2 - 0.20% Coverage

We've even moved quarters and he's kinda been away

<Files\\Participant 002 transcript 2 NC> - § 1 reference coded [0.56% Coverage]

Reference 1 - 0.56% Coverage

this whole house I furnished, there is not one piece of furniture that he was with me for us to buy, I've done it all.

<Files\\Participant 006 transcript 2 NC> - § 2 references coded [0.64% Coverage]

Reference 1 - 0.25% Coverage

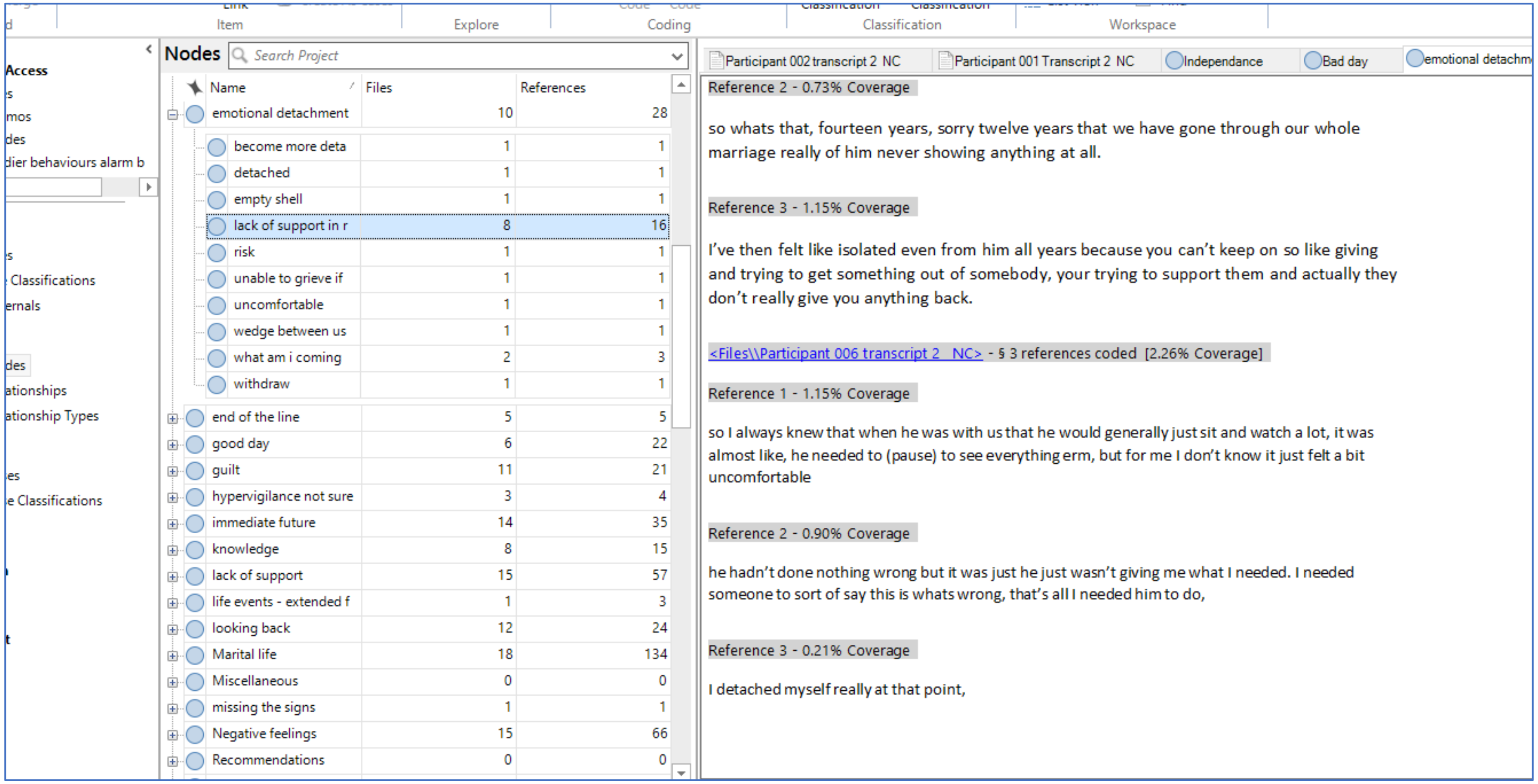
I just tried to make a life for myself really

Reference 2 - 0.40% Coverage

I just make my own friends, my own fun and a job, got myself a little job.

<Files\\Participant 009 transcript 1 NC> - § 1 reference coded [0.27% Coverage]

Reference 1 - 0.27% Coverage



Name	Files	References
emotional detachment	10	28
become more deta	1	1
detached	1	1
empty shell	1	1
lack of support in r	8	16
risk	1	1
unable to grieve if	1	1
uncomfortable	1	1
wedge between us	1	1
what am i coming	2	3
withdraw	1	1
end of the line	5	5
good day	6	22
guilt	11	21
hypervigilance not sure	3	4
immediate future	14	35
knowledge	8	15
lack of support	15	57
life events - extended f	1	3
looking back	12	24
Marital life	18	134
Miscellaneous	0	0
missing the signs	1	1
Negative feelings	15	66
Recommendations	0	0

Reference 2 - 0.73% Coverage

so whats that, fourteen years, sorry twelve years that we have gone through our whole marriage really of him never showing anything at all.

Reference 3 - 1.15% Coverage

I've then felt like isolated even from him all years because you can't keep on so like giving and trying to get something out of somebody, your trying to support them and actually they don't really give you anything back.

<Files\\Participant 006 transcript 2 NC> - § 3 references coded [2.26% Coverage]

Reference 1 - 1.15% Coverage

so I always knew that when he was with us that he would generally just sit and watch a lot, it was almost like, he needed to (pause) to see everything erm, but for me I don't know it just felt a bit uncomfortable

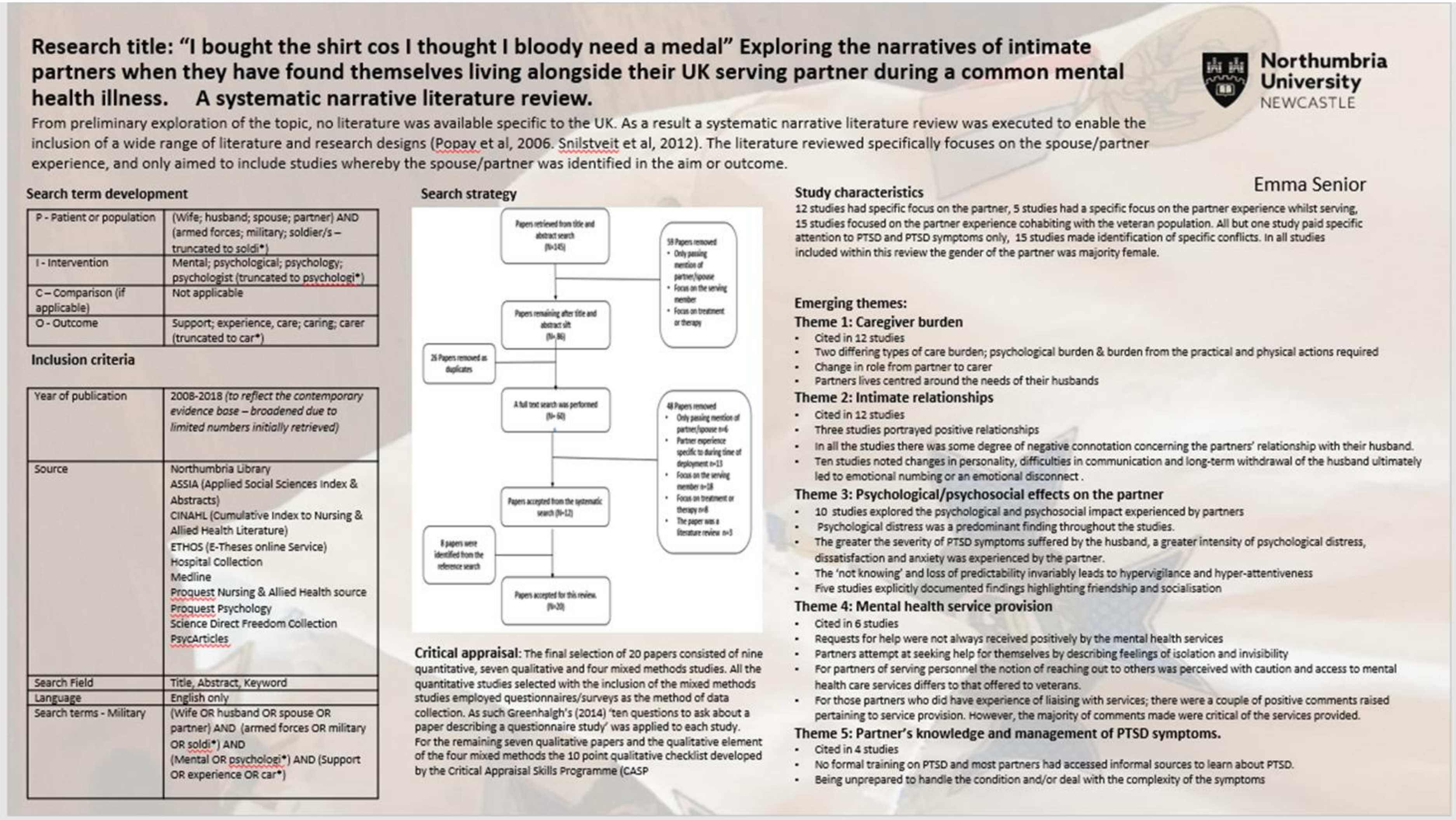
Reference 2 - 0.90% Coverage

he hadn't done nothing wrong but it was just he just wasn't giving me what I needed. I needed someone to sort of say this is whats wrong, that's all I needed him to do,

Reference 3 - 0.21% Coverage

I detached myself really at that point,

8.15 Appendix 15 – Conference poster- Early Researcher Conference



Research title: "I bought the shirt cos I thought I bloody need a medal" Exploring the narratives of intimate partners when they have found themselves living alongside their UK serving partner during a common mental health illness. A systematic narrative literature review.

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From preliminary exploration of the topic, no literature was available specific to the UK. As a result a systematic narrative literature review was executed to enable the inclusion of a wide range of literature and research designs (Popay et al, 2006. Snilstveit et al, 2012). The literature reviewed specifically focuses on the spouse/partner experience, and only aimed to include studies whereby the spouse/partner was identified in the aim or outcome.

Emma Senior

Search term development

P - Patient or population	(Wife; husband; spouse; partner) AND (armed forces; military; soldier/s – truncated to soldi*)
I - Intervention	Mental; psychological; psychology; psychologist (truncated to psychologi*)
C – Comparison (if applicable)	Not applicable
O - Outcome	Support; experience, care; caring; carer (truncated to car*)

Inclusion criteria

Year of publication	2008-2018 *(to reflect the contemporary evidence base – broadened due to limited numbers initially retrieved)*
Source	Northumbria Library ASSIA (Applied Social Sciences Index & Abstracts) CINAHL (Cumulative Index to Nursing & Allied Health Literature) ETHOS (E-Theses online Service) Hospital Collection Medline Proquest Nursing & Allied Health source Proquest Psychology Science Direct Freedom Collection PsycArticles
Search Field	Title, Abstract, Keyword
Language	English only
Search terms - Military	(Wife OR husband OR spouse OR partner) AND (armed forces OR military OR soldi*) AND (Mental OR psychologi*) AND (Support OR experience OR car*)

Search strategy

Papers retrieved from title and abstract search (N=145)

59 Papers removed
- Only passing mention of partner/spouse
- Focus on the serving member
- Focus on treatment or therapy

Papers remaining after title and abstract sift (N= 86)

26 Papers removed as duplicates

A full text search was performed (N= 60)

48 Papers removed
- Only passing mention of partner/spouse n=6
- Partner experience specific to during time of deployment n=13
- Focus on the serving member n=18
- Focus on treatment or therapy n=8
- The paper was a literature review n=3

Papers accepted from the systematic search (N=12)

8 papers were identified from the reference search

Papers accepted for this review. (N=20)

Critical appraisal: The final selection of 20 papers consisted of nine quantitative, seven qualitative and four mixed methods studies. All the quantitative studies selected with the inclusion of the mixed methods studies employed questionnaires/surveys as the method of data collection. As such Greenhalgh's (2014) 'ten questions to ask about a paper describing a questionnaire study' was applied to each study. For the remaining seven qualitative papers and the qualitative element of the four mixed methods the 10 point qualitative checklist developed by the Critical Appraisal Skills Programme (CASP

Study characteristics

12 studies had specific focus on the partner, 5 studies had a specific focus on the partner experience whilst serving, 15 studies focused on the partner experience cohabiting with the veteran population. All but one study paid specific attention to PTSD and PTSD symptoms only, 15 studies made identification of specific conflicts. In all studies included within this review the gender of the partner was majority female.

Emerging themes:

Theme 1: Caregiver burden
- Cited in 12 studies
- Two differing types of care burden; psychological burden & burden from the practical and physical actions required
- Change in role from partner to carer
- Partners lives centred around the needs of their husbands

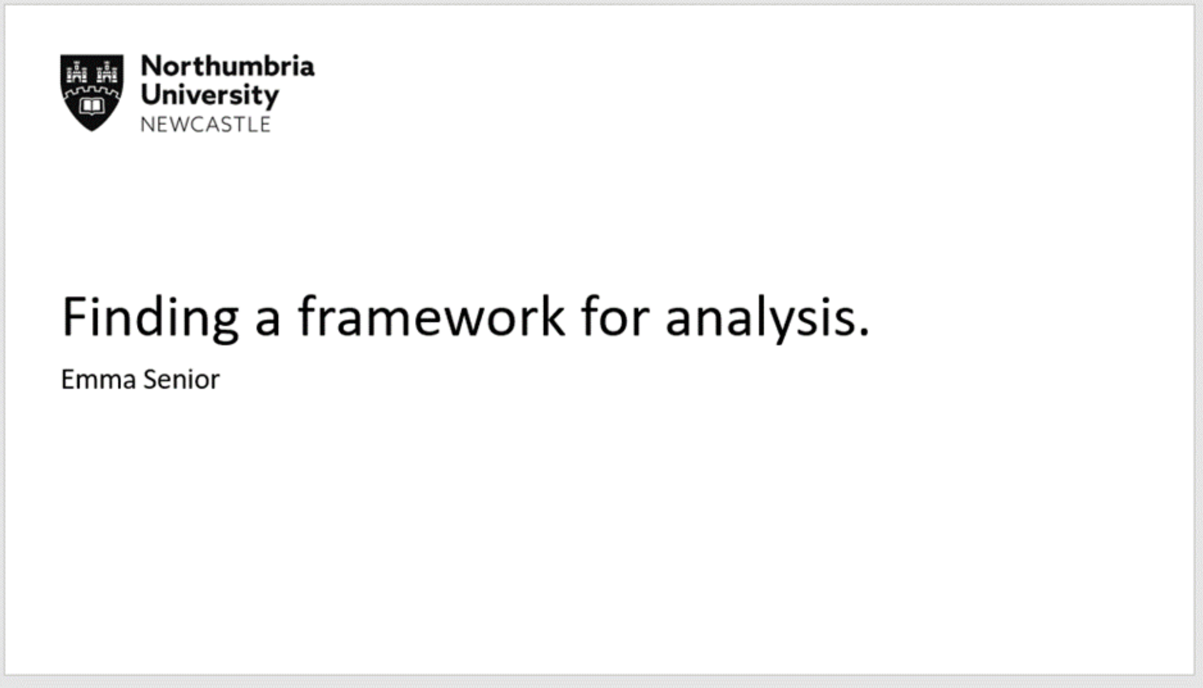
Theme 2: Intimate relationships
- Cited in 12 studies
- Three studies portrayed positive relationships
- In all the studies there was some degree of negative connotation concerning the partners' relationship with their husband.
- Ten studies noted changes in personality, difficulties in communication and long-term withdrawal of the husband ultimately led to emotional numbing or an emotional disconnect .

Theme 3: Psychological/psychosocial effects on the partner
- 10 studies explored the psychological and psychosocial impact experienced by partners
- Psychological distress was a predominant finding throughout the studies.
- The greater the severity of PTSD symptoms suffered by the husband, a greater intensity of psychological distress, dissatisfaction and anxiety was experienced by the partner.
- The 'not knowing' and loss of predictability invariably leads to hypervigilance and hyper-attentiveness
- Five studies explicitly documented findings highlighting friendship and socialisation

Theme 4: Mental health service provision
- Cited in 6 studies
- Requests for help were not always received positively by the mental health services
- Partners attempt at seeking help for themselves by describing feelings of isolation and invisibility
- For partners of serving personnel the notion of reaching out to others was perceived with caution and access to mental health care services differs to that offered to veterans.
- For those partners who did have experience of liaising with services; there were a couple of positive comments raised pertaining to service provision. However, the majority of comments made were critical of the services provided.

Theme 5: Partner's knowledge and management of PTSD symptoms.
- Cited in 4 studies
- No formal training on PTSD and most partners had accessed informal sources to learn about PTSD.
- Being unprepared to handle the condition and/or deal with the complexity of the symptoms

8.16 Appendix 16 - Postgraduate research conference presentation



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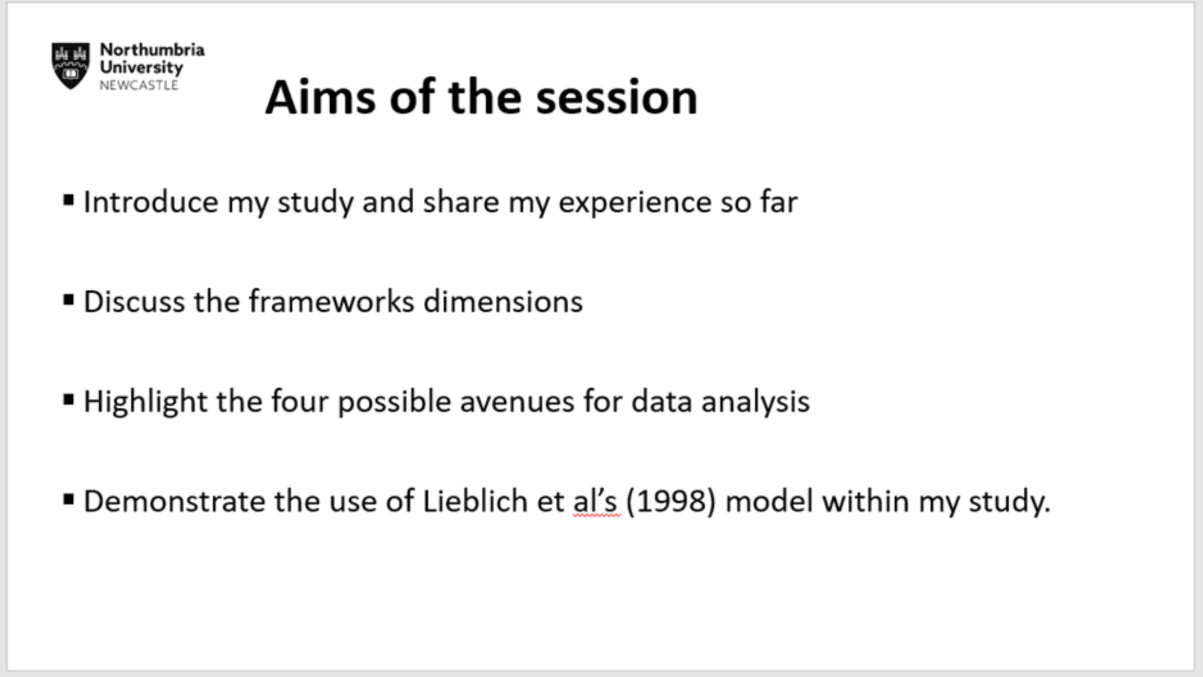
Finding a framework for analysis.

Emma Senior



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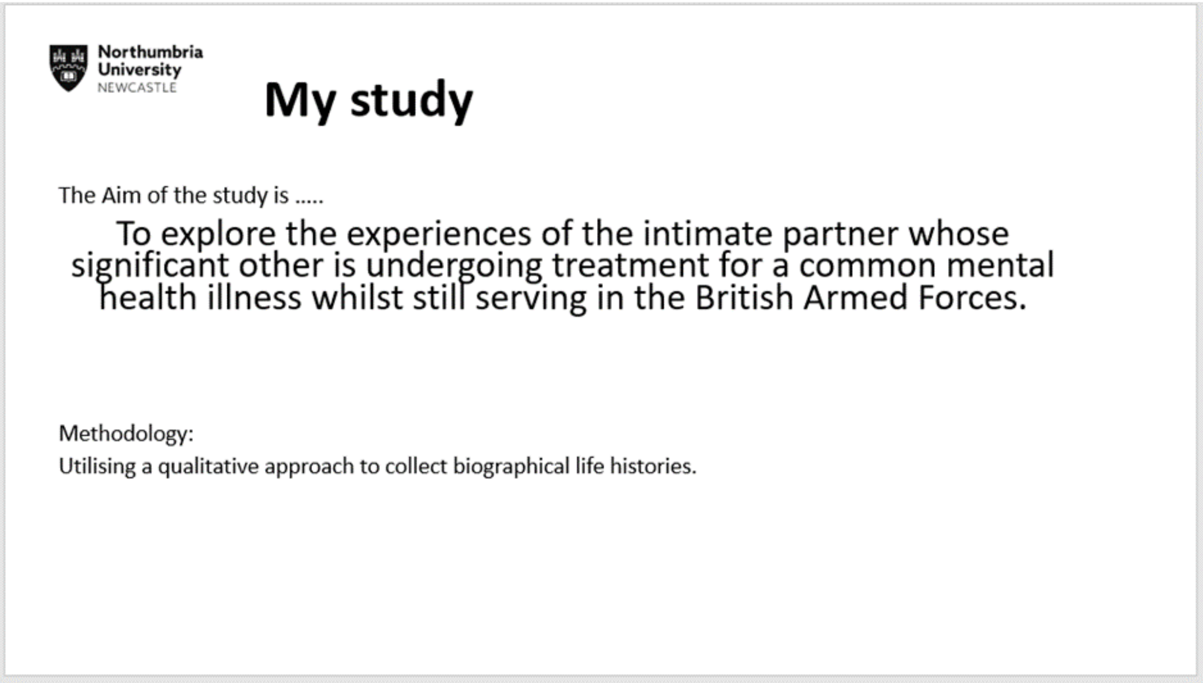
Aims of the session

- Introduce my study and share my experience so far
- Discuss the frameworks dimensions
- Highlight the four possible avenues for data analysis
- Demonstrate the use of Lieblich et al's (1998) model within my study.



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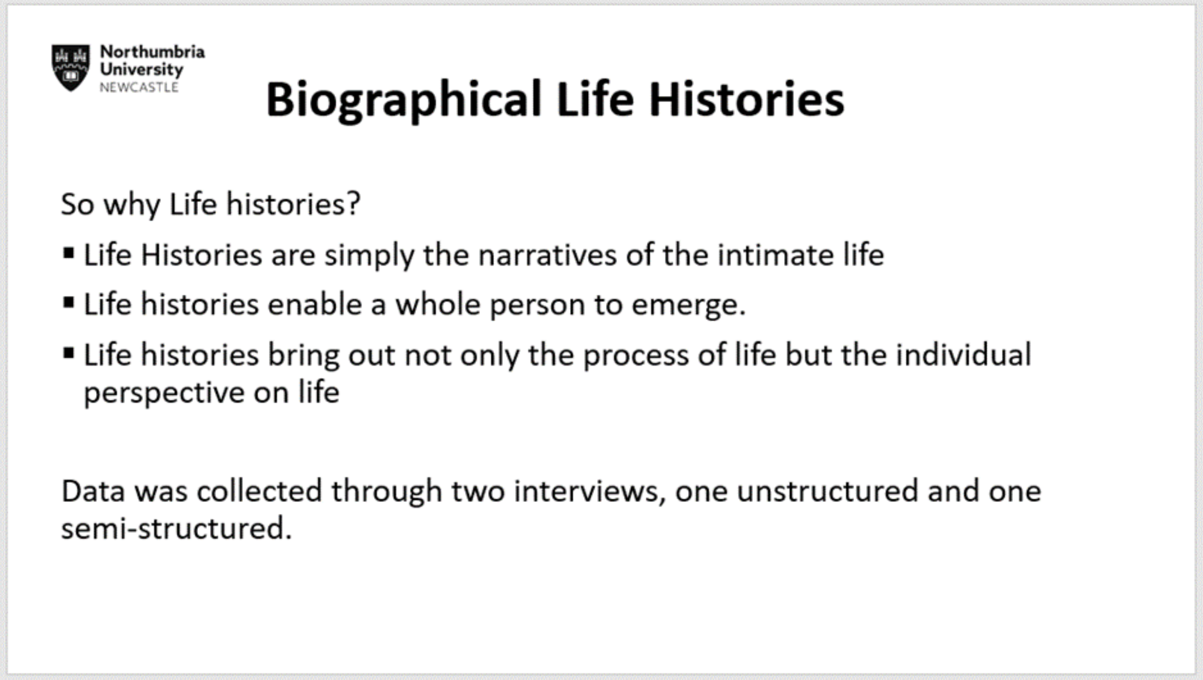
My study

The Aim of the study is …..

To explore the experiences of the intimate partner whose significant other is undergoing treatment for a common mental health illness whilst still serving in the British Armed Forces.

Methodology:
Utilising a qualitative approach to collect biographical life histories.



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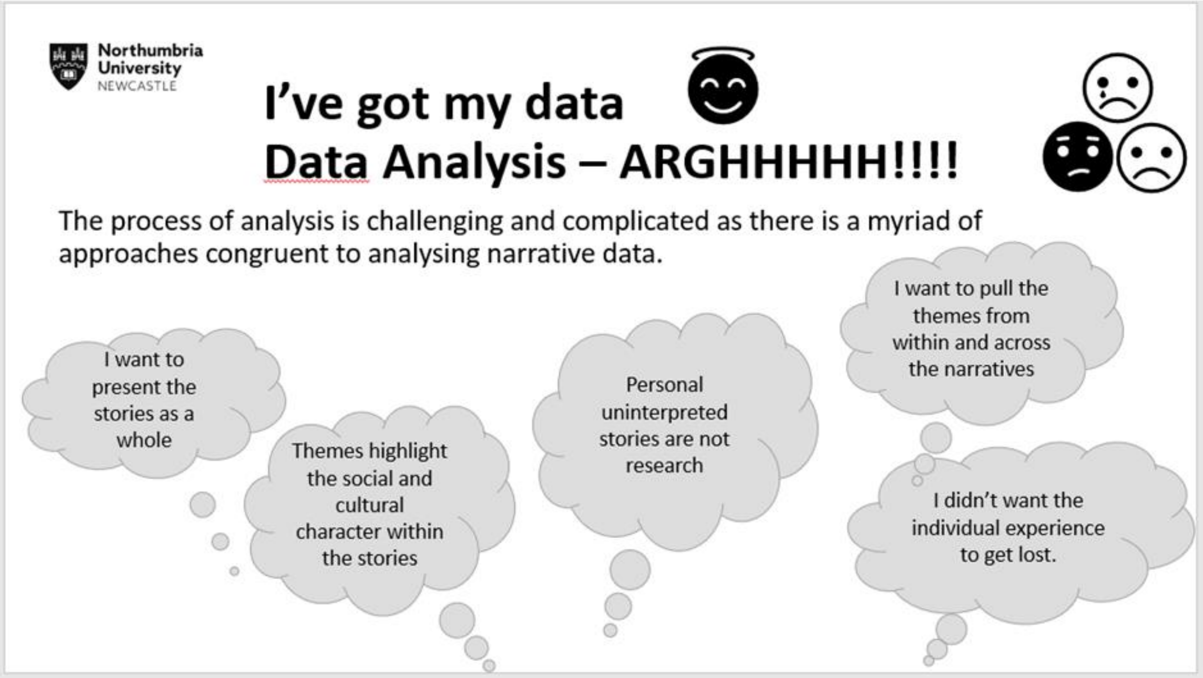
Biographical Life Histories

So why Life histories?

- Life Histories are simply the narratives of the intimate life
- Life histories enable a whole person to emerge.
- Life histories bring out not only the process of life but the individual perspective on life

Data was collected through two interviews, one unstructured and one semi-structured.



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I've got my data
Data Analysis – ARGHHHHH!!!!

The process of analysis is challenging and complicated as there is a myriad of approaches congruent to analysing narrative data.

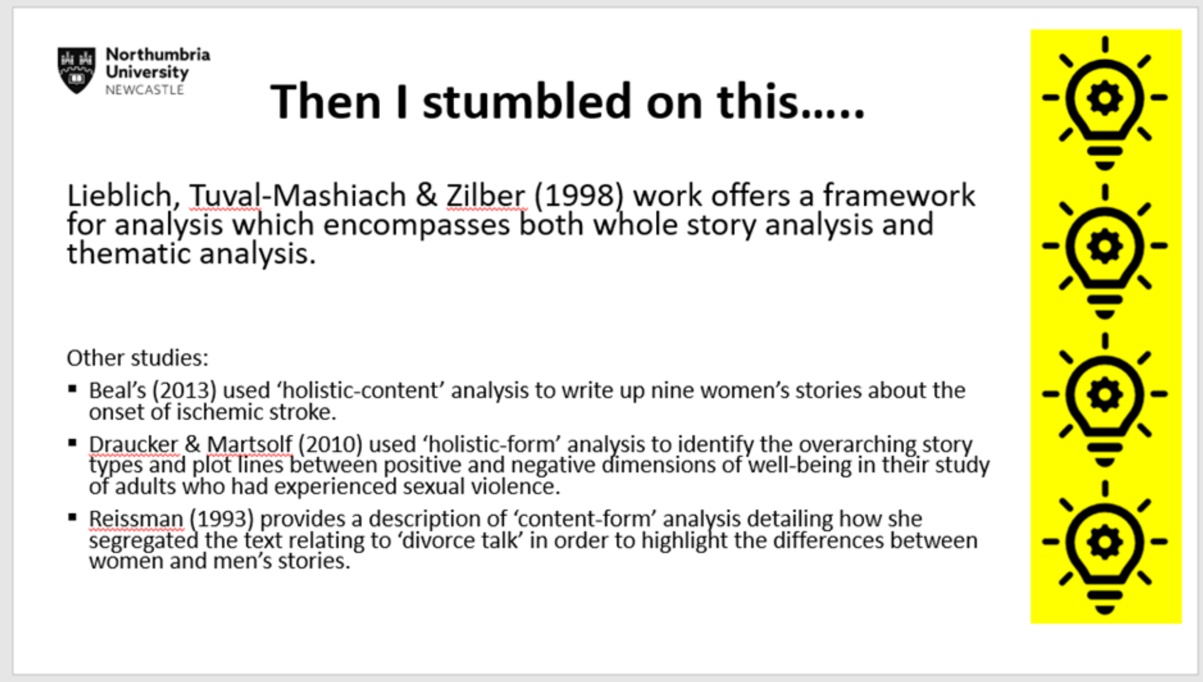
I want to present the stories as a whole

Themes highlight the social and cultural character within the stories

Personal uninterpreted stories are not research

I want to pull the themes from within and across the narratives

I didn't want the individual experience to get lost.



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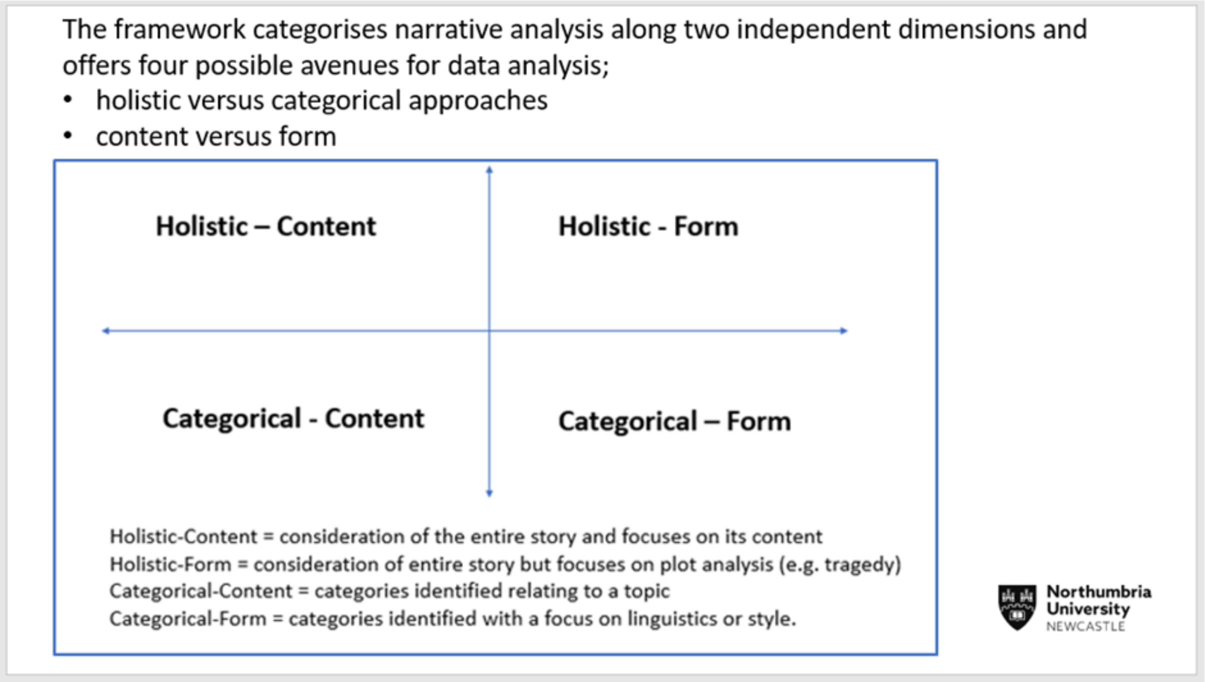
Then I stumbled on this.....

Lieblich, Tuval-Mashiach & Zilber (1998) work offers a framework for analysis which encompasses both whole story analysis and thematic analysis.

Other studies:

- Beal's (2013) used 'holistic-content' analysis to write up nine women's stories about the onset of ischemic stroke.
- Draucker & Martsolf (2010) used 'holistic-form' analysis to identify the overarching story types and plot lines between positive and negative dimensions of well-being in their study of adults who had experienced sexual violence.
- Reissman (1993) provides a description of 'content-form' analysis detailing how she segregated the text relating to 'divorce talk' in order to highlight the differences between women and men's stories.



The framework categorises narrative analysis along two independent dimensions and offers four possible avenues for data analysis;

- holistic versus categorical approaches
- content versus form

Holistic – Content

Holistic - Form

Categorical - Content

Categorical – Form

Holistic-Content = consideration of the entire story and focuses on its content
Holistic-Form = consideration of entire story but focuses on plot analysis (e.g. tragedy)
Categorical-Content = categories identified relating to a topic
Categorical-Form = categories identified with a focus on linguistics or style.

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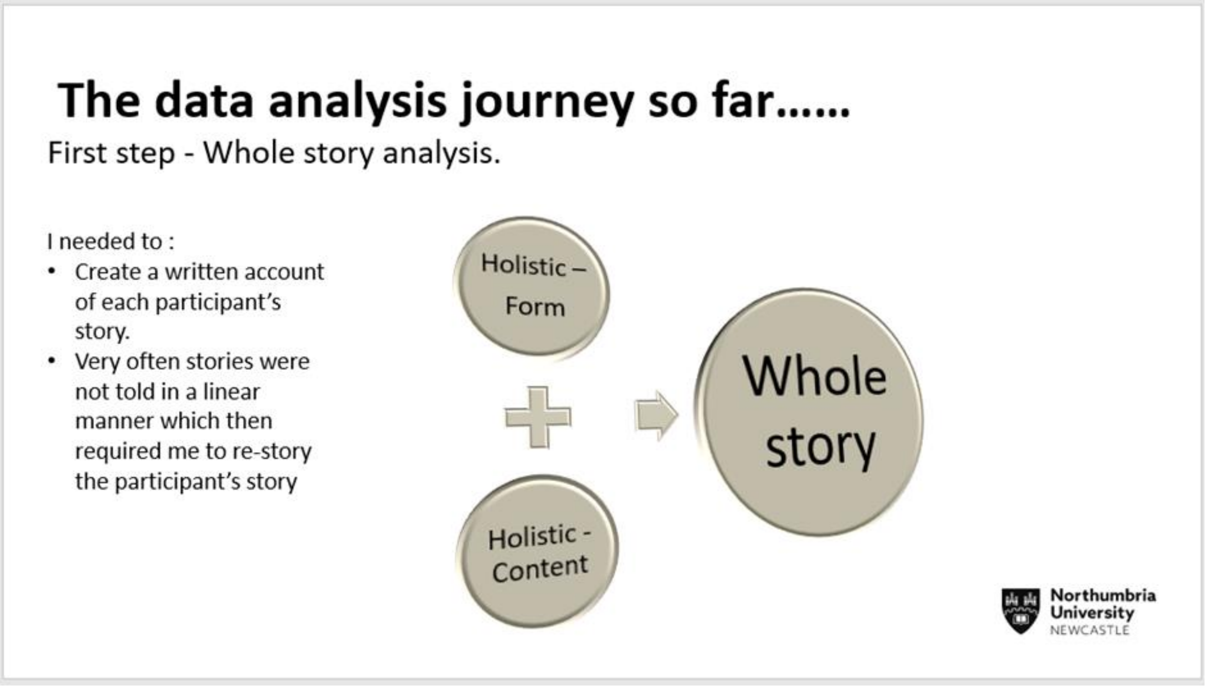

The data analysis journey so far……

First step - Whole story analysis.

I needed to :

- Create a written account of each participant's story.
- Very often stories were not told in a linear manner which then required me to re-story the participant's story

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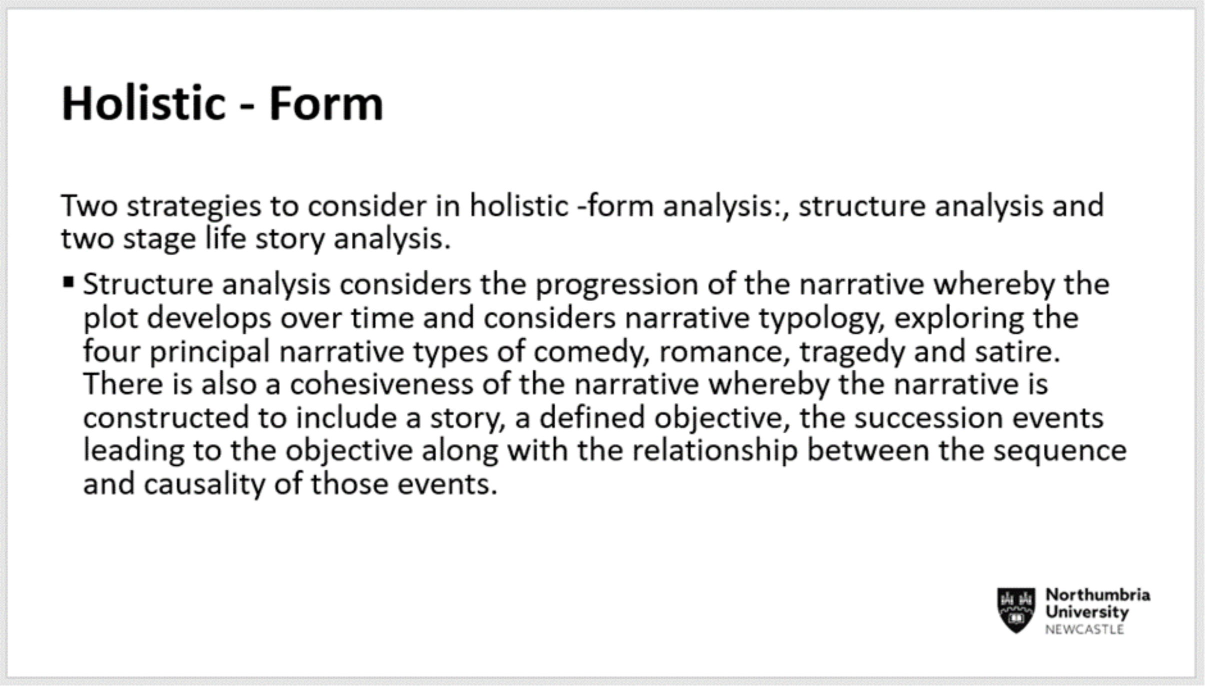

Holistic - Form

Two strategies to consider in holistic -form analysis:, structure analysis and two stage life story analysis.

- Structure analysis considers the progression of the narrative whereby the plot develops over time and considers narrative typology, exploring the four principal narrative types of comedy, romance, tragedy and satire. There is also a cohesiveness of the narrative whereby the narrative is constructed to include a story, a defined objective, the succession events leading to the objective along with the relationship between the sequence and causality of those events.

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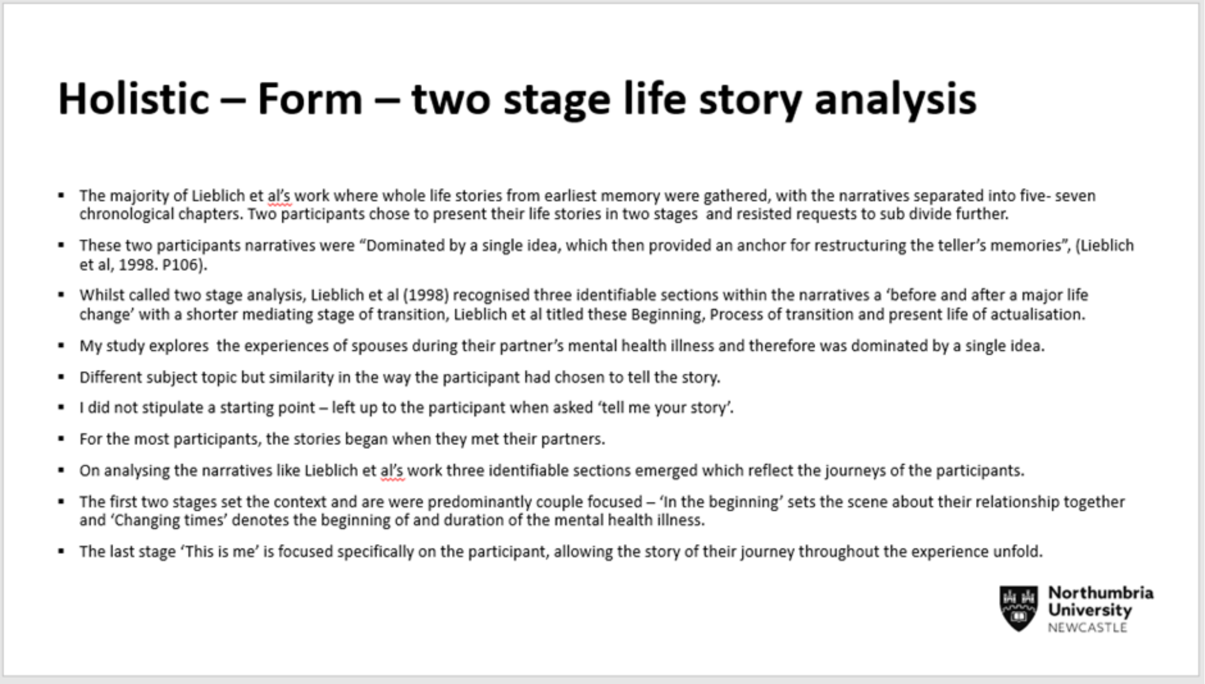

Holistic – Form – two stage life story analysis

- The majority of Lieblich et al's work where whole life stories from earliest memory were gathered, with the narratives separated into five- seven chronological chapters. Two participants chose to present their life stories in two stages and resisted requests to sub divide further.
- These two participants narratives were "Dominated by a single idea, which then provided an anchor for restructuring the teller's memories", (Lieblich et al, 1998. P106).
- Whilst called two stage analysis, Lieblich et al (1998) recognised three identifiable sections within the narratives a 'before and after a major life change' with a shorter mediating stage of transition, Lieblich et al titled these Beginning, Process of transition and present life of actualisation.
- My study explores the experiences of spouses during their partner's mental health illness and therefore was dominated by a single idea.
- Different subject topic but similarity in the way the participant had chosen to tell the story.
- I did not stipulate a starting point – left up to the participant when asked 'tell me your story'.
- For the most participants, the stories began when they met their partners.
- On analysing the narratives like Lieblich et al's work three identifiable sections emerged which reflect the journeys of the participants.
- The first two stages set the context and are were predominantly couple focused – 'In the beginning' sets the scene about their relationship together and 'Changing times' denotes the beginning of and duration of the mental health illness.
- The last stage 'This is me' is focused specifically on the participant, allowing the story of their journey throughout the experience unfold.

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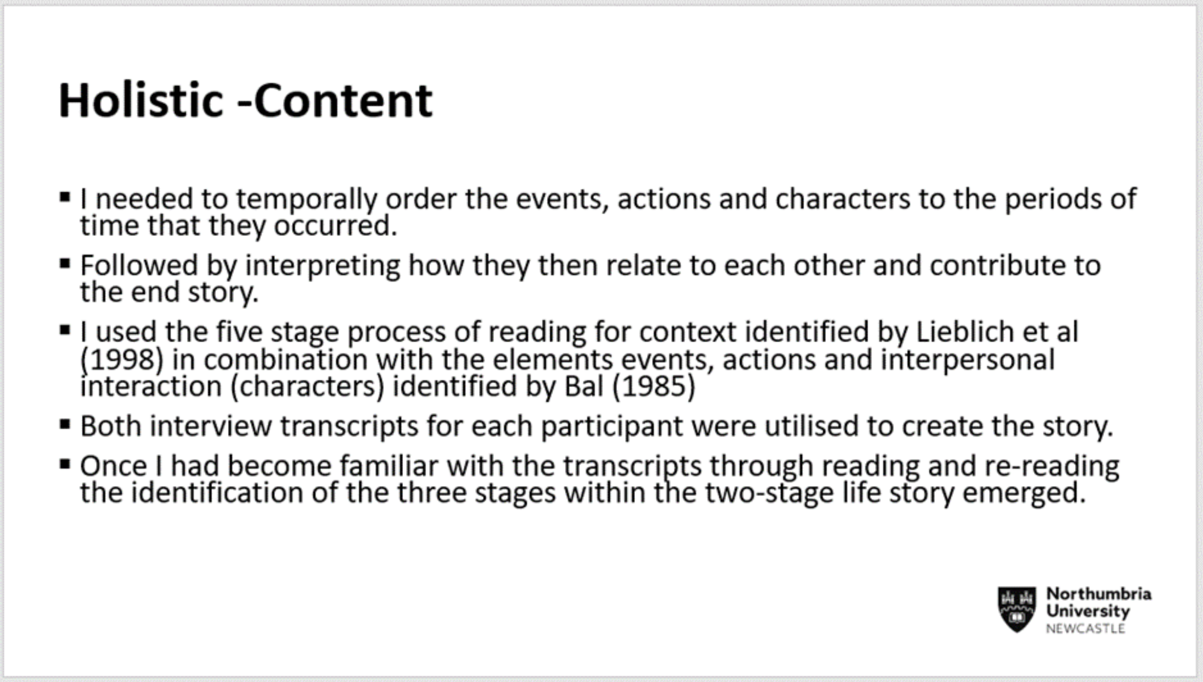

Holistic -Content

- I needed to temporally order the events, actions and characters to the periods of time that they occurred.
- Followed by interpreting how they then relate to each other and contribute to the end story.
- I used the five stage process of reading for context identified by Lieblich et al (1998) in combination with the elements events, actions and interpersonal interaction (characters) identified by Bal (1985)
- Both interview transcripts for each participant were utilised to create the story.
- Once I had become familiar with the transcripts through reading and re-reading the identification of the three stages within the two-stage life story emerged.

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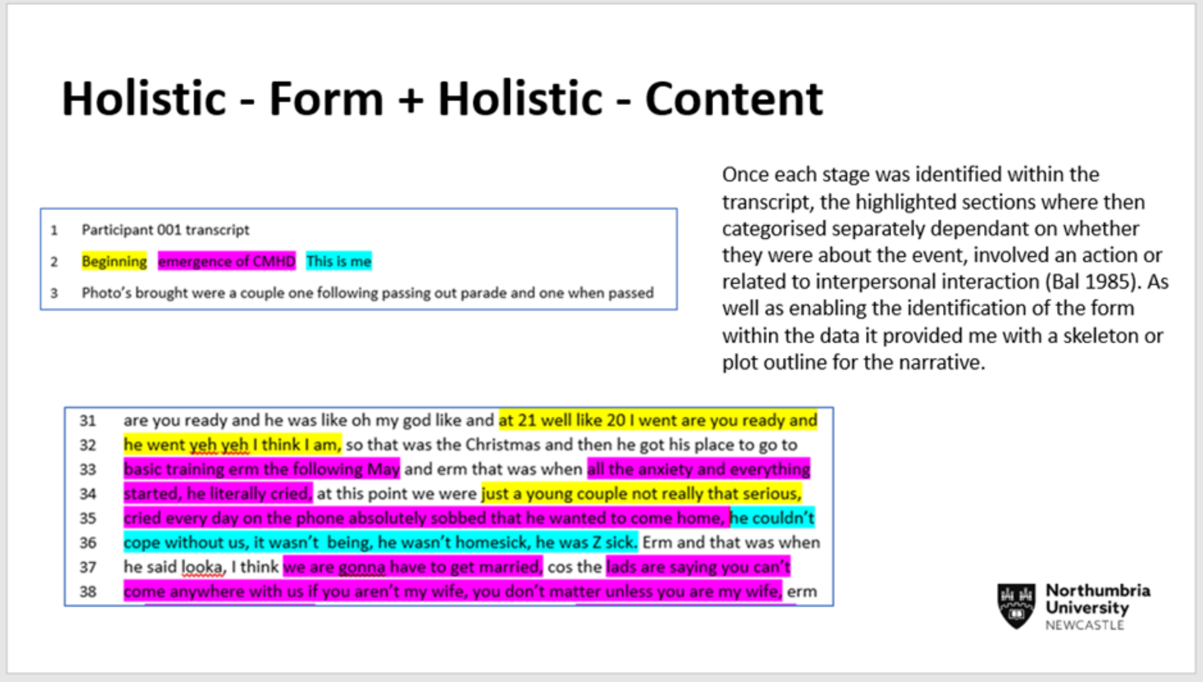

Holistic - Form + Holistic - Content

Participant 001 transcript

Beginning emergence of CMHD This is me

Photo's brought were a couple one following passing out parade and one when passed

Once each stage was identified within the transcript, the highlighted sections where then categorised separately dependant on whether they were about the event, involved an action or related to interpersonal interaction (Bal 1985). As well as enabling the identification of the form within the data it provided me with a skeleton or plot outline for the narrative.

are you ready and he was like oh my god like and at 21 well like 20 I went are you ready and he went yeh yeh I think I am, so that was the Christmas and then he got his place to go to basic training erm the following May and erm that was when all the anxiety and everything started, he literally cried, at this point we were just a young couple not really that serious, cried every day on the phone absolutely sobbed that he wanted to come home, he couldn't cope without us, it wasn't being, he wasn't homesick, he was Z sick. Erm and that was when he said looka, I think we are gonna have to get married, cos the lads are saying you can't come anywhere with us if you aren't my wife, you don't matter unless you are my wife, erm

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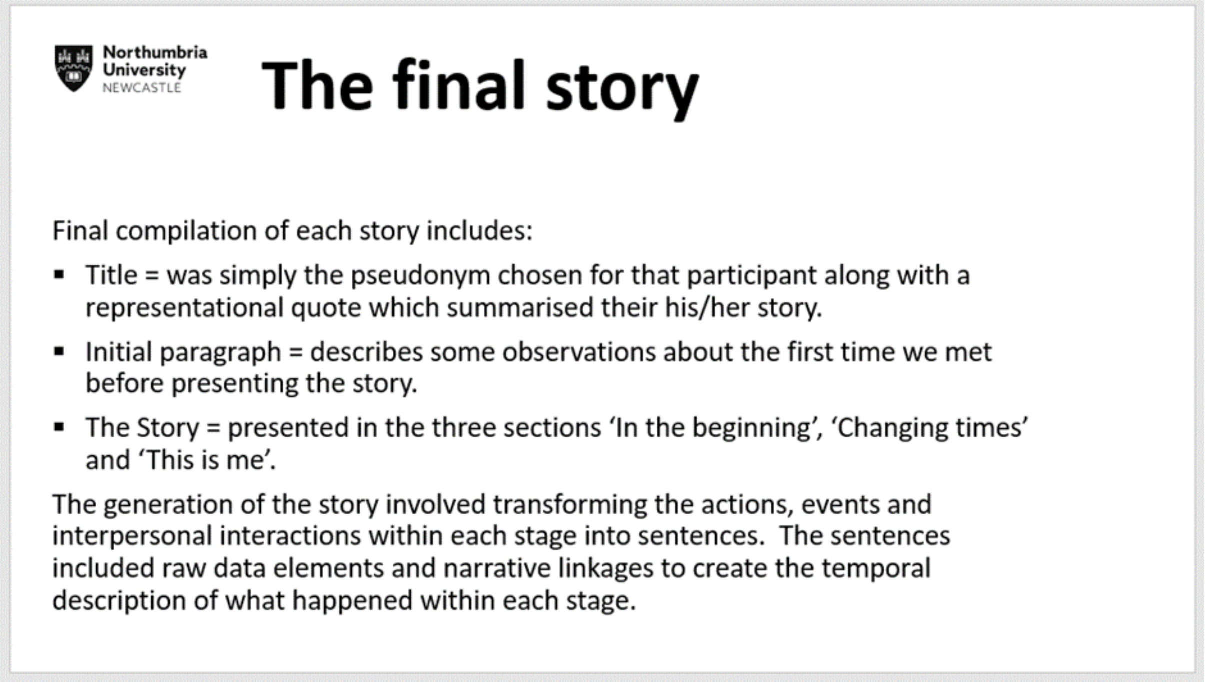

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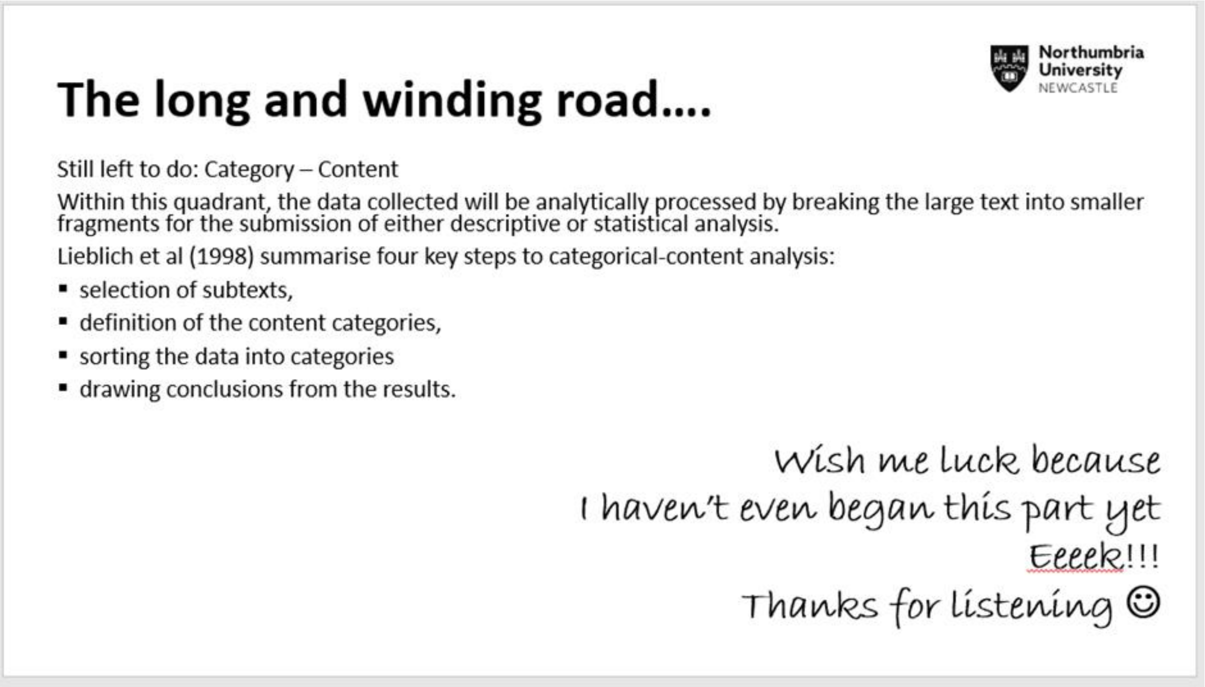
The final story

Final compilation of each story includes:

- Title = was simply the pseudonym chosen for that participant along with a representational quote which summarised their his/her story.
- Initial paragraph = describes some observations about the first time we met before presenting the story.
- The Story = presented in the three sections 'In the beginning', 'Changing times' and 'This is me'.

The generation of the story involved transforming the actions, events and interpersonal interactions within each stage into sentences. The sentences included raw data elements and narrative linkages to create the temporal description of what happened within each stage.



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The long and winding road….

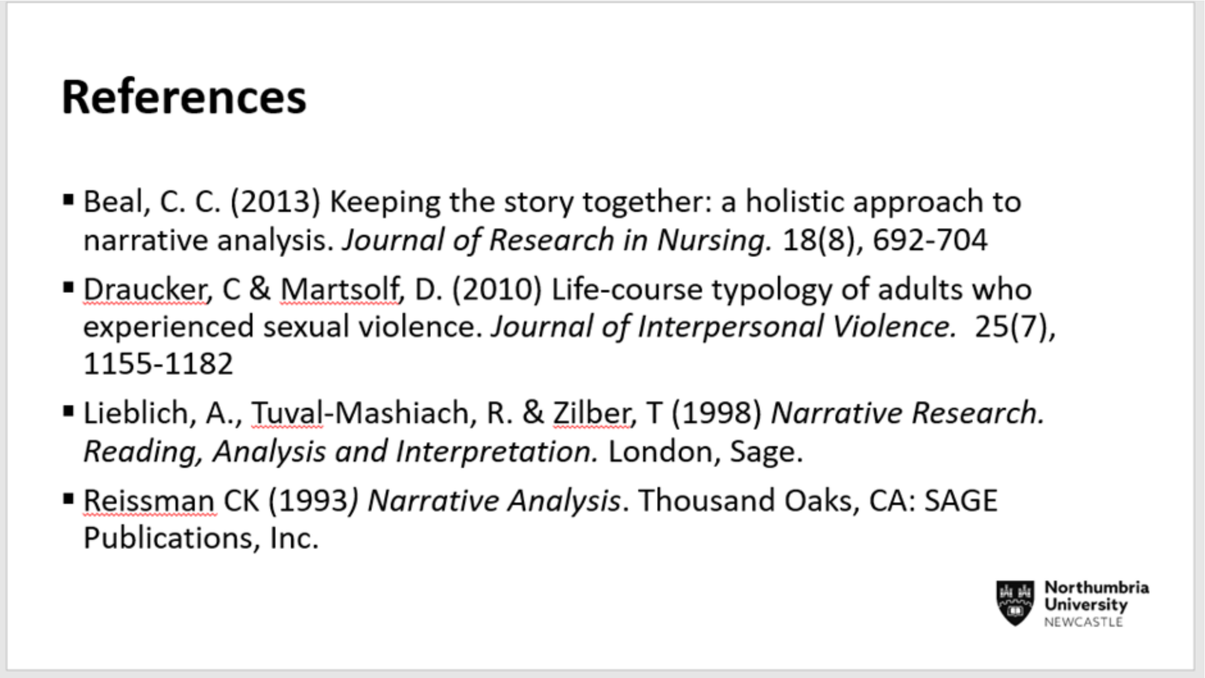
Still left to do: Category – Content

Within this quadrant, the data collected will be analytically processed by breaking the large text into smaller fragments for the submission of either descriptive or statistical analysis.

Lieblich et al (1998) summarise four key steps to categorical-content analysis:

- selection of subtexts,
- definition of the content categories,
- sorting the data into categories
- drawing conclusions from the results.

Wish me luck because
I haven't even began this part yet
Eeeek!!!
Thanks for listening ☺



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